

OUTCOMES OF ANTHROPOLOGICALLY BASED CULTURAL COMPETENCY
EDUCATION FOR DOCTORAL STUDENTS IN PHYSICAL THERAPY

By
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ABSTRACT

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Researchers have developed tools to assess the impact of cultural awareness, sensitivity, and competency programs in health services. These tools are unreliable, lacking in validity, based on provider self-report, and limited in overall scope and rigor. Neither methodology nor evaluation exists of *what* content is most effective in cultural competency education or *how* health care providers use knowledge and skills to enhance clinical encounters. The goal of this dissertation is to better understand the usefulness of cultural competency education for students in physical therapy. This research examines (1) how participants used cultural competency education at the point of clinical engagement, (2) if increased amount of education translates into greater motivation for application, (3) and which cultural competency skills are most useful in the clinical setting. It concludes with recommendations for improving cultural competency for clinical students.

Key words: cultural competency, medical anthropology, physical therapy, health disparity, cultural assessment, clinical professionalism

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CHAPTER ONE

Introduction: Health Disparity and Cultural Competency

Health disparity is the difference between two or more populations in health outcomes and access to appropriate health services.

Cultural competence is a set of behaviors, attitudes, and policies that come together in systems and organizations so professionals may work effectively in cross-cultural situations (Cross et al. 1989:13).

Health disparity is an embarrassing outcome for American health services: ethnic minority populations are reliably overrepresented among those with the worst health. Reducing health disparity as the sentinel indicator of quality in health care gained national attention with the publication of *Crossing the Quality Chasm: A New Health System for the 21st Century* (Committee on the Quality of Health Care in America and Institute of Medicine 2003). The study found that care is not consistently provided to all populations in the United States, which creates degrees of disparity in health. Two principles for redesign emerged to tackle disparity: providing care that is customized to patient needs and values; and allowing patients to be the source of control in the medical encounter (Committee on the Quality of Health Care in America and Institute of Medicine 2001). The Institute of Medicine recommends educating and better preparing the health services workforce to respond and adapt to diverse patient needs as the primary strategy for addressing disparity.

Quality in health care is measured in a variety of ways, including the process of care, patient-improved access to services, appropriate utilization of services, patient satisfaction, patient and provider adherence to treatment guidelines, health outcomes, system efficiency, and cost-effectiveness (Fortier and Bishop 2003). One of the most critical dimensions of quality is the moment of clinical exchange between patient and provider. Balsa and McGuire (2001) argue

that three mechanisms contribute to disparity from the provider's level of exchange: bias, clinical uncertainty, and beliefs or stereotypes about health behavior. Of particular interest is the underresearched dimension of disparity related to factors that affect uncertainty in discretionary clinical decision making. "Any degree of uncertainty a [health provider] may have relative to the condition of a patient can contribute to disparities in treatment . . . [providers] must depend on inferences about severity based on what they can see about illness . . . operating with prior beliefs" (Smedley, Stith, and Nelson 2004:26). Van Ryn (2000, 2002) found that provider heuristic processes influence the quality of care related to disparity in the time-restricted clinical encounter. When providers are unsure about clinical signals they place weight on prior beliefs regarding age, gender, religion, sexual orientation, socioeconomic status, race, or ethnicity. Diagnostic decisions then are unmatched with patients' needs (Smedley, Stith, and Nelson 2004:26). Patient mistrust, refusal of treatment, and compliance additionally can affect outcomes, but: "It is clear that the healthcare provider, rather than the patient, is the more powerful actor in the clinical encounters. Providers' expectations, beliefs, attitudes, and behaviors are therefore likely to be a more important target for intervention efforts" (Smedley, Stith, and Nelson 2004:29).

Reducing health disparity became a medical educational priority when Congress prompted research and publication of *Unequal Treatment: Confronting Racial and Ethnic Disparity in Health Care* (Smedley, Stith, and Nelson 2004). Finding 4-1 of the study indicated that "Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. Although indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research," resulting in study

recommendation 6-1: “Integrate cross-cultural education into the training of all current and future health professionals” (ibid. 2004:29, 37). Authors of the report recommended, “A comprehensive, multi-level strategy [was] needed to eliminate these disparities,” including placing the greatest burden in reducing disparity on the role of “rigorously evaluated” provider cross-cultural education, or what is now known as cultural competency (CC) (ibid.:1-2).

Cultural competency for health providers is not a new idea. Sensitivity to patients’ cultural needs gained attention in the fields of nursing and mental health in the 1970s, but policy change intended to impact health disparity brought the term “cultural competency” into fashion (Lo and Stacey 2008). Today, professional organizations including the American Medical Association (AMA), the Commission of Accreditation of Healthcare Management Education (CAHME), The Joint Commission, the Council on Education for Public Health (CEPH), the Institute of Medicine (IOM), the Office of Minority Health (OHM), and the Agency for Healthcare Research and Quality (AHRQ), each have formal policy statements and recommendations for CC education. The current trend requiring CC evaluation for program accreditation is driven by national standards and aims to create a workforce, systems of care, and organizational environments that can best adapt to patients’ needs, regardless of cultural background, race, ethnicity, or primary language.

Health professions’ education programs provide CC training in varied formats, from a few contact hours introducing students to the role of culture in health and health care to infusing courses across the curriculum. Cultural competency content often was added to programs with little evaluation because policy mandates pushed required content before educational models could be fully conceptualized. Researchers (Bernal and Froman 1987; Crosson et al. 2004; Thom et al. 2006; Sheu and Lent 2007; Krainovich-Miller et al. 2008) have developed tools to

assess the impact of cultural awareness, sensitivity, and competency programs. Unfortunately, these tools often are unreliable, lacking in validity, based on provider self-report, and limited in overall scope and rigor (Price et al. 2005; Kuman-Tan et al. 2007).

Educators, policy makers, and providers agree that CC education is critical in health services without proof that CC education reduces health disparity (Betancourt, Green, and Carrillo 2002; Betancourt Carrillo, Green, and Aneneh-Firempong 2003; Betancourt and Green 2010; Kagawa-Singer and Kassim-Lakha 2003; and Hobgood, et al. 2006). Some approaches to CC show promise for improving knowledge, attitude, and specific skills, but few have demonstrated an effect on improving health outcomes for diverse populations (Beach et al. 2005). Most studies do not fully describe their methods of educational intervention and rarely has baseline cultural competency and exposure been weighed alongside current provider attitudes (Lie et al. 2010:323). No studies have demonstrated that one type of “cultural learning” is better than another, but there is limited evidence that exposure to cultural information, regardless of its method or duration, results in improved provider attitude and skill. Improved attitudes were associated with confidence in providing care to diverse populations and interest in learning about patient and family backgrounds. Improved skills were demonstrated by providers increasing their involvement in community-based outreach, increased interaction with peers of different races and ethnicities, and improved ability to conduct treatment plans with diverse patients (Beach et al. 2005:5).

Ten years have passed since formal recommendations highlighted the importance of cultural competency education for health professionals and we still don’t have a good understanding of its result. Researchers often focus on correlating the cause and effect relationship between CC education and patient health outcomes with limited success. I have

abandoned the belief that these outcome measures are attainable because of variations in simply trying to define culture, but remain convinced that care can be better *culturally informed* by improving how clinical students are educated. Neither methodology nor evaluation currently exists of *what* content is most effective in CC education, *which* methods best prepare clinical providers to respond to diverse populations, or *how* health care providers use CC knowledge and skills to enhance clinical exchange (Brach and Fraserirector 2000; Fortier and Bishop 2003; Beach et al. 2005; Lie et al. 2010).

CHAPTER TWO

Cultural Competency in Clinical Curricula

Most clinical and health professions' education programs provide CC within the formal educational setting or through postgraduate residency programs (Fortier and Bishop 2003). Conceptual formats are presented in one or a combination of three techniques: 1) attitude-based -- teaching cultural sensitivity; 2) knowledge-based – developing historical and culturally specific frameworks for practitioners; or 3) skill-based – advancing communication, cultural liaisons, and negotiation skills (Kripalani et al. 2006:1116). The attitude-based approach includes teaching clinical and health services students to appreciate cultural differences and respect the needs of diverse clients. Emphasis includes superficial creation of organizational environments that appeal to diverse groups of patients and their motive to participate in their own health outcomes. Cultural sensitivity is demonstrated with methods such as focused social-marketing messages and intervention strategies (Resnicow et al. 1999:10). The knowledge-based approach involves exposing students to common health beliefs and behaviors for the primary ethnic groups students *most likely* will encounter. For example, by teaching students about such perceptions as hot and cold dichotomies among Mexican immigrants, health educators believe they will be prepared to respond appropriately to patients with health events believed to have a cultural underpinning. The skill-based approach focuses on teaching students how to elicit differences in explanatory models and how to use translators and cultural brokers (Kripalani et al. 2006:1116).

Cultural competency education is taught most commonly through didactic methods. Most programs “generally dedicate only a small portion of their curricular time to discussion of

cultural competence as it relates to patient care [and] little attention is given to cross-cultural issues during students' clinical rotations" (ibid.). Such approaches fail to foster competency that leads to student's ability to respond to the diverse needs of all patients (Crosson et al. 2004). Simplistic cultural sensitivity, historical, and cultural-specific educational approaches may be more likely to instill stereotyping, oversimplification of events, and evolve into providers making unfounded, overconfident assumptions about their patients (see Betancourt 2004; Betancourt, Green, and Carrillo 2002; Betancourt et al. 2003; Betancourt et al. 2005; Chin 2000; Smith et al. 2007; van Ryn and Fu 2003). These methods fail to integrate what may be more essential, longitudinal, and durable anthropological insight, such as cultural variation in framing health, sickness, and disease (Janzen 2002), teaching cultural humility (Tervalon and Murray-Garcia 1998), the idea that cultural competence is more than technical skill (Kleinman 2006), methods of clinical ethnography (Kleinman 2006), the idea that diversity accounts for more than ethnicity, nationality, and language (Kleinman 2006), and the nature of biomedicine as culturally constructed authoritative reality with its own limitations (Janzen 2003).

Panels that formulate education standards require most clinical programs to integrate *some type* of CC content to fulfill accreditation requirements. How content is provided and evaluated is dependent on program interpretation. Some clinical programs provide education on 14 culturally and linguistically appropriate services in health care (CLAS) standards (see Appendix A). The purpose of these guidelines is to address health inequity and be responsive to patient needs through three themes: (1) culturally competent care, (2) language access services, and (3) organizational supports for cultural competence (US Department of Health and Human Services 2001). Only four of the standards are mandated, all of which apply to translation services. Healthcare organizations must comply with translation standards for receipt of

federally administrated funding; while the remaining CLAS standards related to CC do not require compliance by medical institutions.

Many competing factors come into play when incorporating CC education into clinical education and health-services environments. Guidance for training exists (see *Cultural Competency in Medical Education: A Guidebook for Schools*, Department of Health and Human Services 2004), yet too often it is added to the tasks of clinical faculty – many of whom have little experience in the core concepts and theory of culture. Studies of nursing faculty (Cuellar et al. 2008; Starr, Shattell, and Gonzales 2011) demonstrate that increased attention to CC education exists in the clinical curriculum, but the faculty presenting the training feel incompetent. These same studies additionally suggest that schools of health professions critically reexamine their expectations of the CC instructional abilities of clinical faculty. Health profession leaders, accreditation committees, and program faculty often insist that CC education is important, but they are unwilling to demonstrate this commitment *within* their curriculum. They are reluctant to alter lock-step processes of clinical education by adding or changing required course work to incorporate more than token contact hours for CC education.

Many clinical education programs are evolving from baccalaureate to master's degrees, and in some cases, advancing to the level of clinical doctorates. This expansion allows programs to adopt and experiment with new curricula. Physical therapy education is one such example. Physical therapists (PTs) now are educated at the doctoral level to be autonomous practitioners who have direct access to patients in over 80 percent of all states (Panzarella 2008). Physical therapy programs have one national accreditation criterion that allows program directors to interpret the following: “Professional Practice Expectation: Cultural Competence CC-5.18 Identify, respect, and act with consideration for patients’/clients’ differences, values, preferences,

and expressed needs in all professional activities” (Committee on Cultural Competence 2008). Two documents, “Blueprint For Teaching Cultural Competence in Physical Therapy Education” (Committee on Cultural Competence 2008) and “A Guide to Cultural Competence in Curriculum” (Panzarella and Matteliano 2008) provide guidance for curriculum infusion with programs granted latitude on implementing content. Both frameworks recommend using a combination of CC teaching models to achieve the general objectives to improve:

1. Student’s cultural awareness;
2. Student’s knowledge of diverse cultures and practices;
3. Student’s skill in the assessment of clients from diverse cultures and practices;
4. Student’s ability to develop treatment plans for clients from diverse cultures; and
5. Student’s desire for culture competence.

Ideally, as recommended by the frameworks, clinical physical therapy faculty with interest or experience in treating “diverse cultures” would introduce these foundations through “one course that has primary responsibility for general cultural awareness training,” with additional infusion throughout the curriculum (ibid.:35). Implementing the frameworks as suggested presents several problems. For example, students are required to read monographs “on the top ten countries of origin of the foreign-born population in the US,” which creates a impression that CC is something applied to foreign populations (ibid.:5). Monographs do expose students to extended narratives, but portray static beliefs about culture viewed through a singular lens of one author, patient, or family. Fieldtrip assignments are also recommended to expand students’ cultural encounters, but become counterproductive when students develop a “spectator” attitude towards others’ lives. The danger then follows when authoritative assumptions take for granted that biomedical clinical judgment is the only way to approach sickness, and that these glimpses

somehow represent the worldview of the masses. Nowhere in the guide is there recommendation that PTs examine biomedicine as its own system of convictions, assumptions, and rituals, or that diversity embodies more than foreign-born patients.

CHAPTER THREE

Cultural Competency and Physical Therapy Education

Cultural competency education has an impact on students' knowledge, awareness, and attitudes, yet there is very little understanding of how CC creates and sustains quality clinical interaction (Fortier and Bishop 2003:11; Brach and Fraserirector 2000:198; Beach et al. 2006; Kripalani et al. 2007:1117). No standardization of clinical CC education or evaluation exists. In a study of 61 educators, Dogra, Giordano, and France (2007:41) found that the majority of respondents (n = 51) "felt that guidelines would be useful," to clarify content and increasing credibility for CC. Alternatively, Fortier and Bishop (2003) argue that standardization of CC education is undesirable resulting in conflicting opinions regarding CC approaches.

Written examination is the most commonly used process for assessing CC in physical therapy programs, and rarely is student competency evaluated in its clinical application (Nayer 1995; Panzarella and Manyon 2007). The Committee on the Quality of Health Care in America and the Institute of Medicine recommend that effective CC outcome assessment involve interdisciplinary collaboration and not remain under the control of only health professions programs (2002:259). Panzarella and Manyon additionally recommend that a stronger "steering effect" should be integrated with CC education so that students expect to be examined on their clinical application to improve synthesis beyond a single course (2008:49).

Another favored model for health professional evaluation includes objective structured clinical examinations (OSCEs) (Dogra 2006:682). OSCEs involve presenting didactic content, followed by clinically observing a student's synthesis and use of information in a standardized or controlled environment. OSCE allows for evaluation of students while they are communicating

with patients, but they remain inadequate for fully assessing CC (Dogra and Wass 2006). The challenge in evaluating clinical interaction, “Is the pitfall of narrowly defining cultural competence in its traditional sense: an easily demonstrable mastery of a finite body of knowledge, and endpoint evidenced largely by comparative quantitative assessments” (Tervalon and Murray-Garcia 1998:118). A potential solution proposed by Kumas-Tan et al. (2007) is to expand what is measured as evidence of cultural competence by using qualitative and mixed methods approaches, such as participant observation and key-informant interviews, as complementary to knowledge assessments.

The Wichita State University (WSU) Department of Physical Therapy took an experimental approach to CC by changing its curriculum from eight introductory contact hours to a required anthropologically based 45 contact hours for all doctoral students beginning January 2011. This approach is rare in physical therapy curricula and demonstrates the *importance* of the subject matter within the entire context of the educational program. I am an instructor in the Department of Public Health Sciences trained in anthropology and public health with privileged access to the clinical students as the instructor of the course; PHS 824 – Cultural Competency. The PHS 824 – Cultural Competency curriculum evolved from my teaching similar content to undergraduate clinical and non-clinical health-professions students for the past 10 years. The course meets once per week for three hours over the course of a 16-week semester. Class format consists of lectures, readings, films, discussions, reflection papers, a field trip, and written examinations. My approach is grounded in anthropologically based cultural theory intended to expand students’ appreciation of the complexity of worldview related to health. I require students read anthropological theory and discussions follow about how the concepts apply to patient treatment. Works include Margaret Lock and Vinh-Kim Nguyen

(2010) on the culture of biomedicine; Cheryl Mattingly (1994, 1998) on the features of “emplotment” and narrative; Linda Garro (in Mattingly and Garro, eds. 2000) on the cultural construction of illness; Byron Good (1994, 1997) on medical belief, rationality, and mental illness context; Marsha Inhorn (1986) on stigma; Arthur Kleinman and Peter Benson (2006) on ethnography in the clinic; John Janzen (2002) on framing illness; Robbie Davis-Floyd and Carolyn Sargent (1997) on authoritative knowledge and patient agency, and Nancy Scheper-Hughes (2003, 2007) on life course and technologies. The course did not include clinical follow-up with feedback at the time of this research. Course- and site-visit evaluations of this curriculum have been favorable, yet its outcomes were not comprehensively evaluated before this research.

CHAPTER FOUR

Methods of Cultural Competency Intervention and Evaluation

This study was cross-sectional. It sampled selected physical therapy doctoral students in Sedgwick County, Kansas, solicited with cooperation of the Physical Therapy Department at Wichita State University. The goals of this research were to: learn more about how PTs approach CC in clinical practice; to evaluate the usefulness of CC education; and to learn if increased amount of education translates into greater motivation for application. The project activities included two educational interventions and evaluation through survey, clinical observation, and interview.

Intervention

The eight-hour intervention took place in January 2010 and the 45-hour intervention was implemented from January 2011 until May 2011 (see Table 1 and Table 2 for curricula comparison). Both groups were first year doctor of physical therapy students and neither group had completed a clinical rotation before receiving the intervention. Both course formats were designed with the same overall goals:

1. To increase self-awareness about dimensions of cultural diversity and its effect on awareness, knowledge, attitudes, and behaviors related to health disparity and health care disparity.
2. To provide knowledge and skills that improve health care delivery with the goal of reducing health disparity.

Students in the eight-hour intervention received basic instruction with limited exposure to anthropological theory. No anthropological readings were required and the short time frame

prevented in-depth exploration of content. Students in the 45-hour intervention received a much more rigorous exposure to anthropological theory through readings and discussion. The 45-hour format also allowed me to expand on the APTA's recommendations by including additional content such as the value of humility and the limitations of the biomedical perspective.

Table 1. Competencies Addressed: Eight-Hour Educational Format

Module Content	Objectives
Cultural Competency and Physical Therapy	<ul style="list-style-type: none"> • Discuss the advantages and limitations of cultural competency education • Review discipline-based standards for cultural competency in health practice • Describe the current demographic change in the United States • Identify factors that contribute to health disparity
Cultural Competency and Health	<ul style="list-style-type: none"> • Define the concept of culture and its impact on health outcomes • Define health and illness from cultural perspective • Recognize how individual worldview shapes perception
Life Course	<ul style="list-style-type: none"> • Define concept of life course • Compare cross-cultural differences in life course construction
Stress, Pain & Religion	<ul style="list-style-type: none"> • Compare cultural differences in perception of stress and pain • Describe role of religion and prayer for stress and pain • Describe cognitive and emotional functions of religion
Personhood, Identity & Gender	<ul style="list-style-type: none"> • Identify factors that contribute to health disparity • Recognize how individual worldview shapes perception
Race & Ethnicity	<ul style="list-style-type: none"> • Define difference between race and ethnicity • Define scientific limitations to concept of race in understanding health and disparity
Health Literacy	<ul style="list-style-type: none"> • Appreciate the limitations of health literacy and cross-cultural communication • Describe negative health outcomes associated

	with low health literacy <ul style="list-style-type: none"> • Introduce importance of congruent explanatory models
Health Communication	<ul style="list-style-type: none"> • Discuss standards and limitation when using translators and interpreters • Recognize the importance of creating culturally competent practice environments • Demonstrate a willingness to incorporate understanding of a patient's view of illness

Table 2. Competencies Addressed: 45-Hour Educational Format

Module Content	Objectives
Cultural Competency & Health	<ul style="list-style-type: none"> • Discuss why cultural competence is an emerging issue of importance in health services • Analyze cultural competency from the provider perspective • Evaluate cultural competency from an institutional, financial, and quality perspective • Review discipline-based standards for cultural competency in health practice • Discuss limitations to outcomes research in cultural competency education • Discuss legal and policy positions requiring demonstrations of cultural competency education for fulfillment of accreditation standards in health services
What's Culture & Why Does it Matter?	<ul style="list-style-type: none"> • Define culture • Explain how culture is learned • Complete class exercises demonstrating worldview formulation
Cultural Meaning of Sickness and Healing	<ul style="list-style-type: none"> • Define health and illness from cultural perspective • Discuss classification and compartmentalization of the body • Discuss construction of sickness (disease vs. "folk illness") • Discuss social role of being sick • Discuss self-care vs. health seeking • Evaluate illness without disease and disease without illness
Demographics & Disparity	<ul style="list-style-type: none"> • Describe factors related to population growth

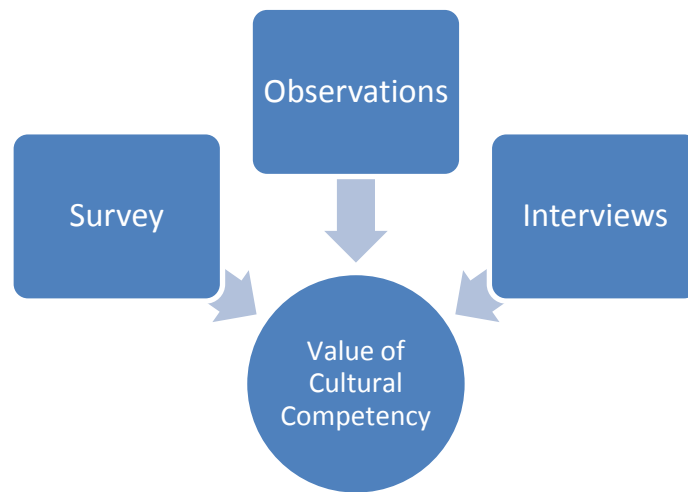
	<ul style="list-style-type: none"> • Describe health disparity and health care disparity • Describe disparate health outcomes
The Biomedical Model	<ul style="list-style-type: none"> • Discuss history of biomedical model • Describe biomedicine's success as shaped by social and political factors • Discuss mind vs. body dichotomy that drives biomedical system • Compare biomedicine to ethnomedicine • Define key concepts of biomedical system
Medical Knowledge, Power & Social Control	<ul style="list-style-type: none"> • Analyze role of "legitimacy" in healing • Debate role of authoritative knowledge in healing • Describe how medical education transforms into power and position • Debate abuse of power in healing • Analyze medicine as a system of social control with its own rules and boundaries • Discuss increasing legitimacy and ownership of all that is "medicalized"
Technologies & Health	<ul style="list-style-type: none"> • Describe how technologies drive change in health services • Describe commodification and branding of technologies • Examine cross-cultural differences in acceptance of technologies
Life Course	<ul style="list-style-type: none"> • Define concept of life course • Discuss biases and definitions of life course stages in Western world • Discuss rites of passage and liminality associated with life course stages • Compare cross-cultural differences in life course construction • Analyze limitations to construct of "aging" • Evaluate medical and legal limitations of birth and death
Personhood, Identity & Gender	<ul style="list-style-type: none"> • Describe notion of personhood • Compare cross-cultural differences in personhood construction • Describe illness as challenge to personhood • Compare cultural variation in identity and gender construction • Discuss health disparity by identity and gender

	<ul style="list-style-type: none"> • Debate identity and gender's effects on social worth of patients
Race & Ethnicity	<ul style="list-style-type: none"> • Define difference between race and ethnicity • Define scientific limitations to concept of race in understanding health and disparity • Debate effects of race and ethnicity in eliciting differing responses from health providers • Discuss "roses" and "thorns" of providing health in a pluralistic society
Bias & Health Research	<ul style="list-style-type: none"> • Discuss history of bias in ethnic and racial studies of health • Describe limitation to current research on race and ethnicity and health outcomes
Stress, Pain & Religion	<ul style="list-style-type: none"> • Describe general adaptation syndrome (GAS) stress model • Analyze combined effect of GAS and culture on health outcomes • Compare cultural differences in perception of stress and pain • Describe role of religion and prayer for stress and pain • Discuss private pain vs. public pain • Describe cognitive and emotional functions of religion • Discuss narrative and chronicity
Mental Health	<ul style="list-style-type: none"> • Discuss cultural characteristics and personality • Discuss over- and misdiagnosis • Define and discuss idioms of distress • Describe culture-bound syndromes
Stigma & Chronicity	<ul style="list-style-type: none"> • Discuss cultural values and stereotypes associated with stigmatized illness • Discuss differences between "having" and "being" • Discuss culture of disability
Health Literacy	<ul style="list-style-type: none"> • Discuss connection between general literacy, health literacy and cultural competency • Discuss culturally and linguistically appropriate services (CLAS) standards and Joint Commission accreditation • Describe negative health outcomes associated with low health literacy • Discuss standards and limitation when using translators and interpreters • Describe importance of congruent explanatory

	models
Humility: The Person-Centered Approach	<ul style="list-style-type: none"> • Evaluate how health services provider's values affect clinical encounters • Discuss provider's responsibility toward positions of humility as necessary professionalism • Debate provider's responsibility to uphold standards that do not abuse power and hierarchy in clinical encounters • Introduce use of ethnographic methods in clinical care
East Asian/Pacific Islanders West Asian/Arabs/Indians	<ul style="list-style-type: none"> • Overview demographics, health outcomes, cultural history, barriers to care, and special services available for specific populations
American Indians Hispanic Populations	<ul style="list-style-type: none"> • Overview demographics, health outcomes, cultural histories, barriers to care and special services available for specific populations
Black Americans European Americans	<ul style="list-style-type: none"> • Overview demographics, health outcomes, cultural histories, barriers to care and special services available for specific populations
Changing the Model Through Cultural Brokering	<ul style="list-style-type: none"> • Define roles of translators, interpreters, and cultural brokers • Debate potentials and challenges in using cultural brokers • Describe and discuss application of community-oriented primary care (COPC) • Discuss how to apply the concept of culture to programs of care • Discuss how to coordinate with traditional healers • Discuss methods for negotiating care for mutual outcomes • Discuss ethical dilemmas that can arise from negotiation of care

I wanted to learn how CC education affected student's clinical practice so I chose a triangulated, mixed-methods approach of survey, observations, and interviews to learn about both common patterns and individual rich points in their thinking (Figure 1).

Figure 1. Triangulated Approach to Learning the Value of Cultural Competency Education



I selected the Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals-Revised (IAPCC-R[®]) (Campinha-Bacote 1998 and 2002, only available by author request) as a baseline survey of general CC. The IAPCC-R[®] is a validated tool recommended by the American Physical Therapy Association (APTA) designed to measure provider and graduate students' attitudes toward CC in health care delivery. The assessment uses 25 four-point Likert scales to measure five constructs of CC: desire, awareness, knowledge, skill, and encounters. It demonstrates excellent reliability (Reliability Coefficient Cronbach's alpha .78 and Guttman Split-half reliability coefficient .77) when used among physical therapy students (Gulas 2005). I added six demographic and basic CC exposure questions as an introductory page to the IAPCC-R[®]. Twelve volunteer students from the eight-hour intervention and 24 students volunteer from the 45-hour intervention completed the 25-minute online survey during the summer of 2012, after they had completed a minimum of two clinical rotations. The survey was solicited via direct email addresses of volunteers and administered through SurveyGizmo.

I created a clinical observation check sheet for assessing PTs behaviors when interacting with patients. The clinical observation check sheet criteria were based on the IAPCC-R[®] and methods introduced in both the eight- and 45-hour interventions for conducting patient assessment, improving patient and provider congruence through negotiation of care, and practicing patient-driven therapy. I observed 32 patient and provider interactions across the eight-hour and 45-hour intervention groups. Clinical observations were coordinated through the Wichita State University Director of Physical Therapy Clinical Education and Clinical Education Coordinators at the selected observation sites under established Clinical Affiliation Agreements between the University and each facility. Observations were recorded using a password-protected, electronic iPad SurveyDeck check sheet (see Appendix C) that additionally allowed for summative fieldnotes.

I designed open-ended interview questions to elicit students' attitudes and motives to apply CC in the clinic, to better understand which competencies and skills were most useful in practice, and to learn if specific educational methods or content were more useful than others. I pilot tested the initial 23 questions with four DPT students who received the 45-hour intervention but whose results were not included in this research. Three questions were retooled for clarity and two questions were edited with additional prompts. Six volunteers from the eight-hour intervention group and 14 volunteers from the 45-hour intervention group completed the semi-structured, open-ended, key-informant face-to-face interviews, lasting approximately 45 minutes (see Appendix D). Interviews were digitally voice recorded using a password-protected iPad application called iRecorder. Digital voice recordings were transcribed by the secure, Web-based professional transcription service Transcription HUB.

Research participation was strictly voluntary and only conducted among individuals 18 years of age or older. Informed consent was provided to participants via email prior to launching the online survey. Consent was assumed upon launch of the survey and participants were instructed to retain a copy of the consent form for their records. Written informed consent was secured prior to clinical observation and key-informant interviews. Participants could withdraw from this study at any time without recourse. All observation and interview data were collected based on facility approval and continued until no new data emerged. Survey data were collected over the course of 30 days in June of 2012. Observation and interview data were collected from June 2012 until September of 2012 through a variety of health services settings. Participants knew in advance the purpose of the scheduled observations and interviews. Data collection was coordinated through the permission of clinical instructors and was based on students' scheduled rotations and appointments. These adaptive arrangements accounted for multiple, unstructured delays in which casual conversations and unstructured observations provided additional insight.

The following questions guided this research:

1. Does CC education improve students' attitudes and motivation for its use?
2. How do physical therapists use CC education in the patient assessment and treatment process?
3. Does increased exposure to formal CC education result in increased motivation for its application?
4. Which cultural competency skills are most useful in the clinical setting?

Data Analysis

I completed frequency counts to determine survey and IAPCC-R[®] results and compared those with observational and interview data. Demonstrations of CC in the patient assessment

and treatment process were independently assessed using the clinical observation check sheet and hand recorded as fieldnotes and partially coded (Strauss and Corbin 1990). Measureable demonstration of CC included the following processes of patient assessment and treatment:

- Providing cultural assessment on all patients
- Addressing the potential of incongruent explanatory models
- Engaging in patient-directed discussion to develop congruence
- Demonstrating willingness to learn of potential worldview differences affecting health perception through discussion
- Acknowledgment of limitation of competence
- Demonstrating skill at negotiating care
- Providing appropriate referrals and service recommendations
- Demonstrating willingness to seek out education, consultation, or training when lack of congruence impedes the assessment or treatment process
- Demonstrating willingness to self-evaluate thinking process when values and beliefs clash

I formally analyzed and converted key-informant semi-structured interviews into frequency distributions to examine the common themes and patterns in PTs thinking and compared the results with the surveys and observations for inconsistencies.

Study Limitations

The greatest threat to this study's validity is that I designed, delivered, and evaluated the intervention. I controlled for this risk by selecting an independent instrument for the measurement of CC, the IAPCC-R[®]. Students who were part of this study received an intervention that I developed and fine-tuned for more than 10 years without knowledge of the

Campinha-Bacote model for CC or the IAPCC-R[®] as a recommended assessment of educational results.

The IAPCC-R[®] assessment tool was not designed for use among graduate students, but rather for practicing health professionals. An Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals – Student Version[®] exists, but is recommended for use among undergraduates. The professional version of the tool (IAPCC-R[®]) is recommended by its author to better represent both the educational stage and practice level of graduate physical therapy students with advanced clinical training and licensed practitioners.

Eight-hour and 45-hour participants were at differing stages of development, which may have affected their attitude and motivation toward CC education and its use in the clinic. Time may have had a differential effect on those who received the intervention in 2010 compared to those in 2011. Students with eight-hours of intervention completed more clinical rotations and were recently graduated and ready to begin working as licensed independent practitioners. Participants with 45-hours of intervention were unlicensed students in their second year of clinical rotations under direct supervision. Ideally I would have evaluated practitioners with similar years at practice.

Students knew one another personally. This intimacy may have biased the results. Students may have responded to unwritten, competitive rules of clinical learning – such as unwillingness to confess they didn't understand the concept of CC. They also may have talked among themselves about my research questions. I took effort to ensure independent responses by reinforcing confidentiality. I also assured students that their contributions would help me shape the CC educational process for future students, but in no way would affect their standing

in the program. Additionally, I conducted observations and interviews during summer rotations while students were away from the classroom, which decreased their constant daily interaction.

Students may have been anxious about reporting dissatisfaction with their education or they might have told me what they *think* I want to know. I created interview probes intended to require them to repeat and clarify their ideas to avoid deference effects. Graduate students have objected to some of my methods in anonymous written course evaluations, but may not have been as forthright during face-to-face interviews so I allowed students the opportunity to provide independent and anonymous written feedback in addition to their verbal responses.

Confidentiality statements and voluntary participation statements stated no information would affect any grade evaluations (past, current, or future) and that no other university administrators, faculty, or employers would have access to student responses.

I expected differences in interview data based on the characteristics of students, how I moderated the interviews, and the differing clinical settings. In some settings I was welcomed; in others I was an intrusion. I conducted some interviews on rigidly scheduled formats in empty, private conference rooms, while others were squeezed into a PTs lunch hour after searching for any quiet space. Students from years past recognized me and wanted to visit. Practitioners who were not part of my research sometimes flaunted their skill and stalked me for conversation as nearly everyone, including patients, was curious about what I was doing. I had little to no control of response effect because of these widely varied conditions.

Some data obtained through the clinical observations and key informant interviews may have been inaccurate for various reasons: informants may have distorted information to conform to their own prejudices; their memory may have failed; they may have misunderstood a question; they may have simply lied; my presence may have altered clinical interactions. Jogging memory

techniques were built into the unstructured interview questions to aid recall, and I did not interrupt or impede clinical practice at any time during my observations.

The sample size is small, so the data may represent sample errors, low generalizability, and limited statistical significance. Interpretation of observations created multiple points for bias and can be viewed as minimizing rigor in research. What I selected as rich points for jottings, how I chose to organize fieldnotes, and which key points I gave preference reflect my reality and may represent contradictory experiences. To curtail such biases, I paid careful attention to recording all fieldnotes on the same day they were observed and carefully followed a predetermined protocol for coding and collapsing the data into themes. Random rechecks on my coding reliability were performed by two volunteer researchers familiar with qualitative content analysis. Both volunteers found the word strings, codes, and themes represented the interview data.

CHAPTER FIVE

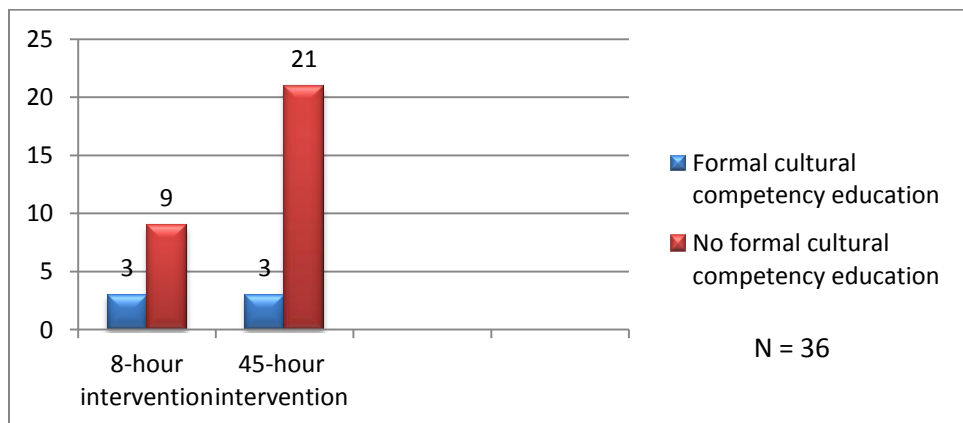
Results

Surveys

Thirty-six students (response rate = 92.31) completed the online survey of general demographics and self-reported levels of CC through the constructs of cultural awareness, knowledge, skill, encounters, and desire, using the IAPCC-R[®] (available only by author request). The majority of students' self-reported ethnicity was white or Caucasian (86.11%), followed by Asian or Asian American (.05%), Middle Eastern (.03%), and Choctaw Caucasian (.03%). Five (13.89%) reported speaking some or limited Spanish, one each (.03%) reported speaking Vietnamese, some German, and American Sign Language.

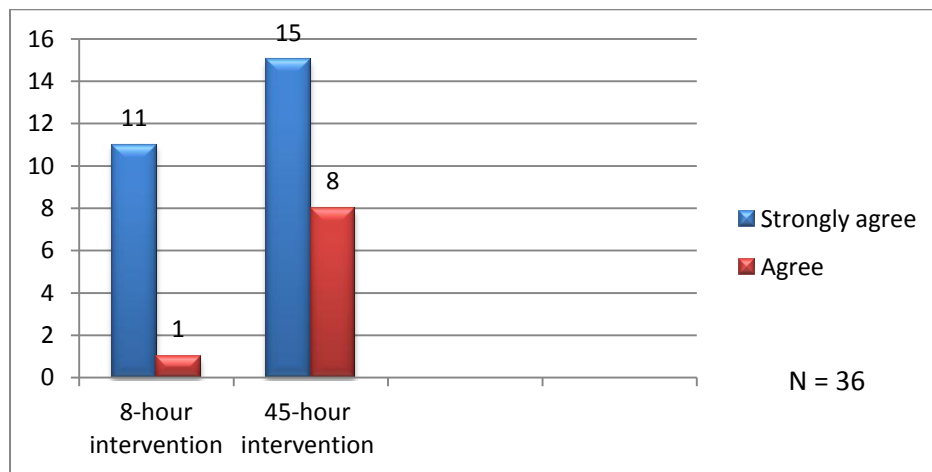
Most students (91.7%, $n = 33$) had no clinical practice experience and the majority (83.3%, $n = 30$) had no formal CC education prior to entering the DPT program of study at Wichita State University (Figure 2). Informal CC education was reported by 17 students in various forms, including personal experience, traveling abroad, work experience and training, and postsecondary courses.

Figure 2. Reported Prior Formal Cultural Competency Education by Intervention Group



The majority of students strongly agreed that CC is an ongoing process (83.3%, n = 30) and reported a personal commitment to care for clients from ethnically or culturally diverse groups (72.2%, n = 26) (Figure 3).

Figure 3. Personal Commitment to Care for Diverse Groups by Intervention Group



All students (n = 36) agreed there is a relationship between culture and health but reported only moderate knowledge of worldviews, beliefs, and practices of two or more culture groups (Figure 4). Six students were not aware of existing assessment tools that can be used with different ethnic groups (Figure 5) and one was not aware of diseases common among different racial and ethnic groups (Figure 6).

Figure 4. Perceived Knowledge of Worldviews, Beliefs, and Practices by Intervention Group

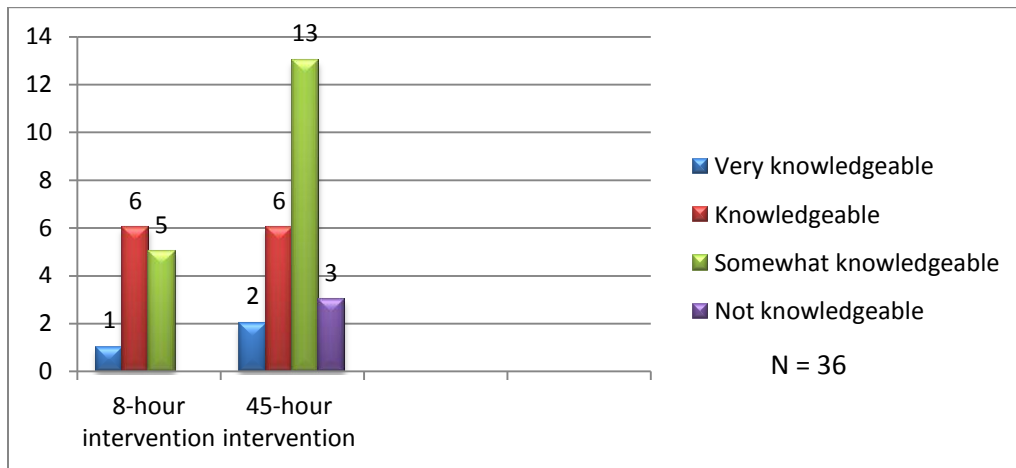


Figure 5. Reported Awareness of Cultural Limitations of Clinical Assessment Tools by Intervention Group

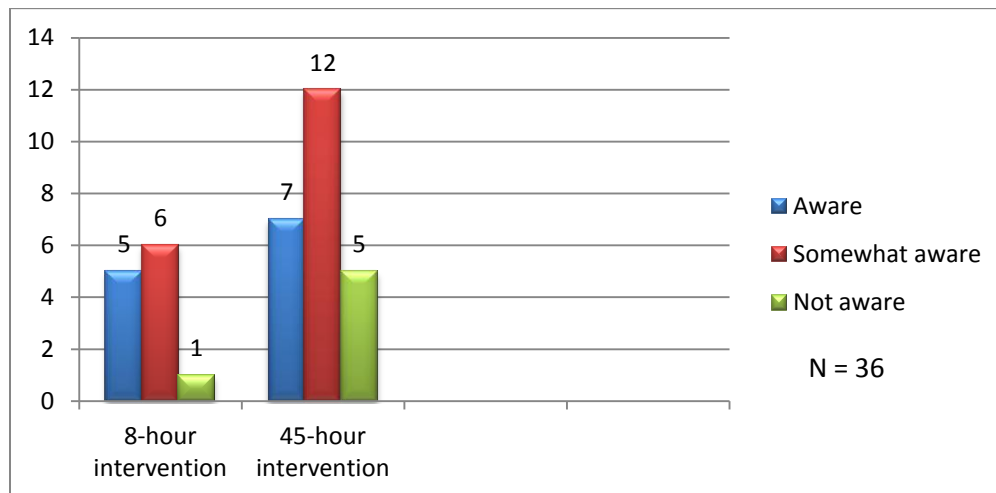
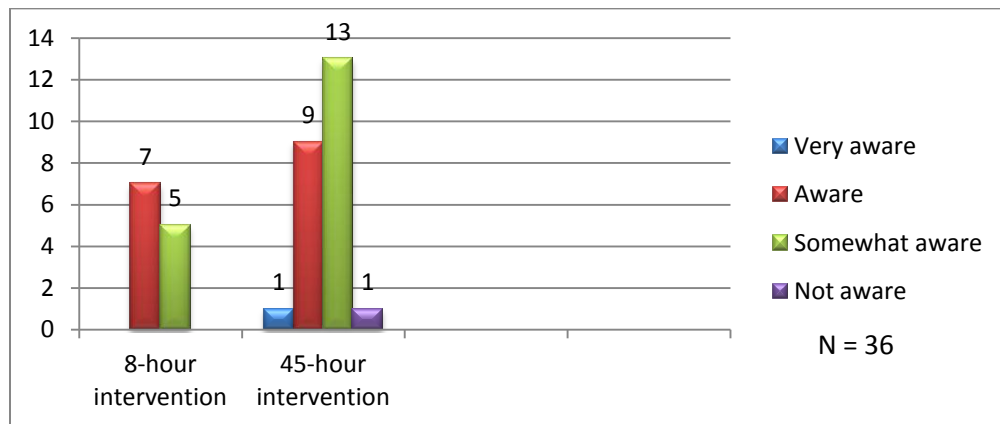
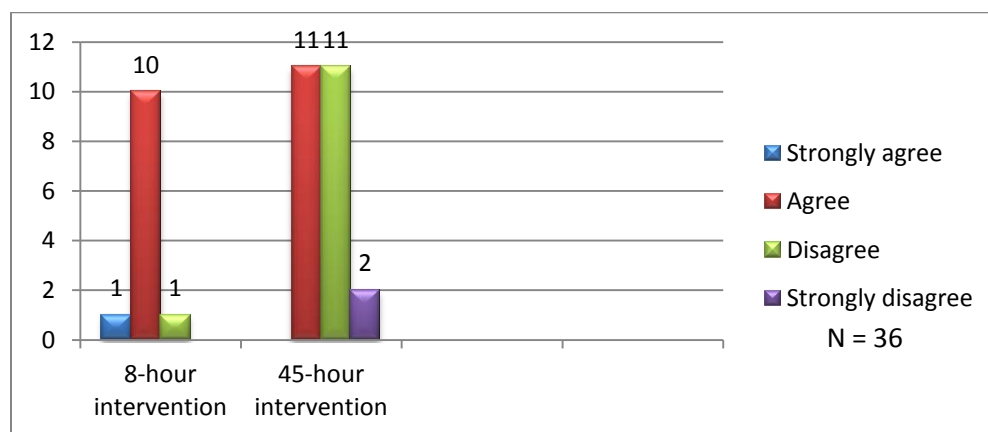


Figure 6. Reported Awareness of Specific Diseases Common Among Ethnic Groups by Intervention Group



Sixty-one percent ($n = 23$) of the students were willing to seek additional CC education, training, or experiences. The percentages were lopsided, with the eight-hour intervention group more likely to strongly agree or agree with its importance than the 45-hour intervention group (Figure 7).

Figure 7. Reported Willingness to Seek Information and Experiences to Enhance CC by Intervention Group



Only 8.3 percent ($n = 3$) of the students reported recognition of their limitations when interacting with cultural and ethnically diverse clients (Figure 8), yet 100 percent ($n = 36$) felt they had, at minimum, some awareness of their own preconceived notions toward members of other ethnic and cultural groups (Figure 9).

Figure 8. Reported Recognition of Limits of Competency by Intervention Group

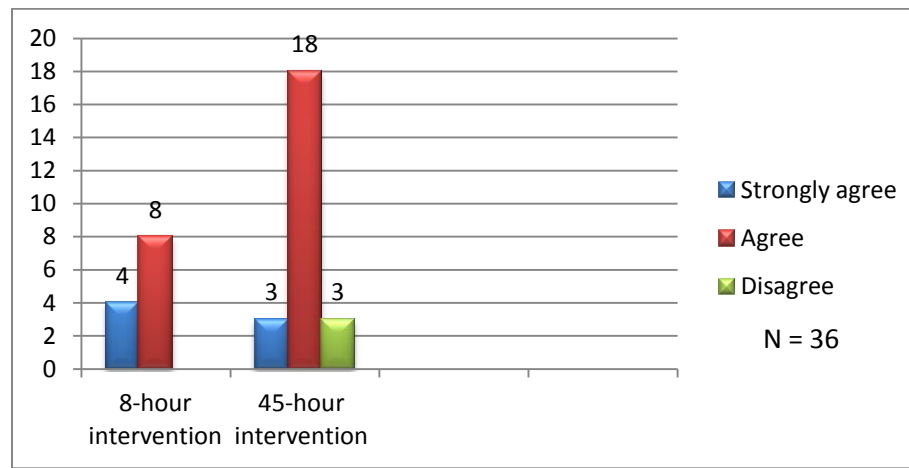
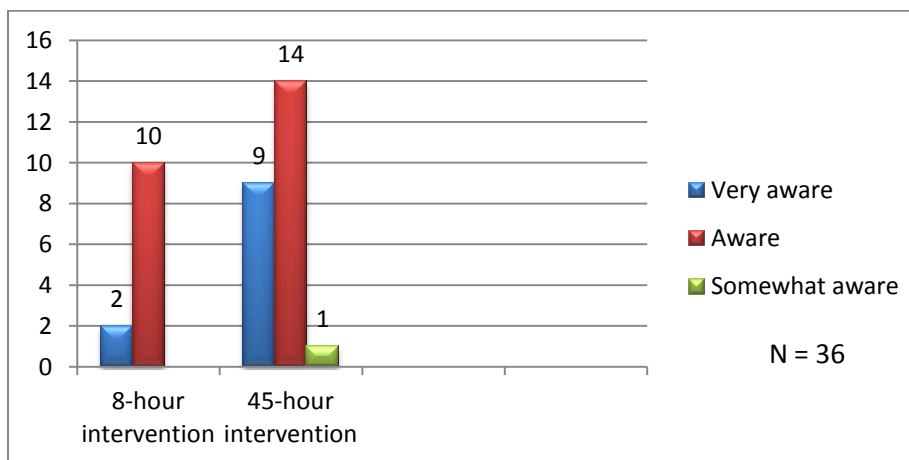
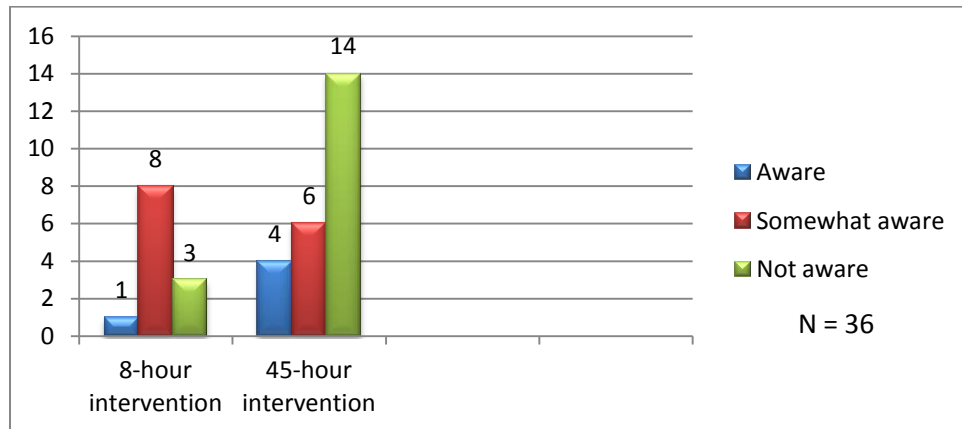


Figure 9. Reported Self-awareness of Stereotyping Beliefs by Intervention Group



No students were very aware and few ($n = 5$) were aware of cultural assessment tools available for use in the clinic (Figure 10).

Figure 10. Reported Awareness of Cultural Assessment Tools by Intervention Group



Twelve students (33.3% of the total sample) thought it more important to conduct a cultural assessment on ethnically diverse clients than on other clients (Figure 11). A larger percentage from the eight-hour intervention group (50% compared with only 16.7% in the 45-hour intervention group) reported likelihood that they would be involved with cultural and ethnic groups other than their own outside of health care settings (Figure 12).

Figure 11. Reported Belief in Importance of Conducting Assessment on Ethnically Diverse Clients Compared to Clients with Similar Ethnicity by Intervention Group

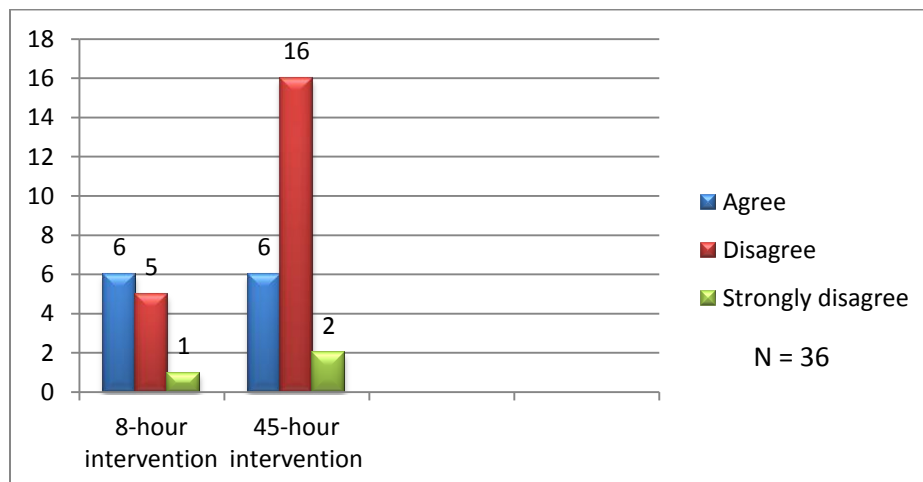
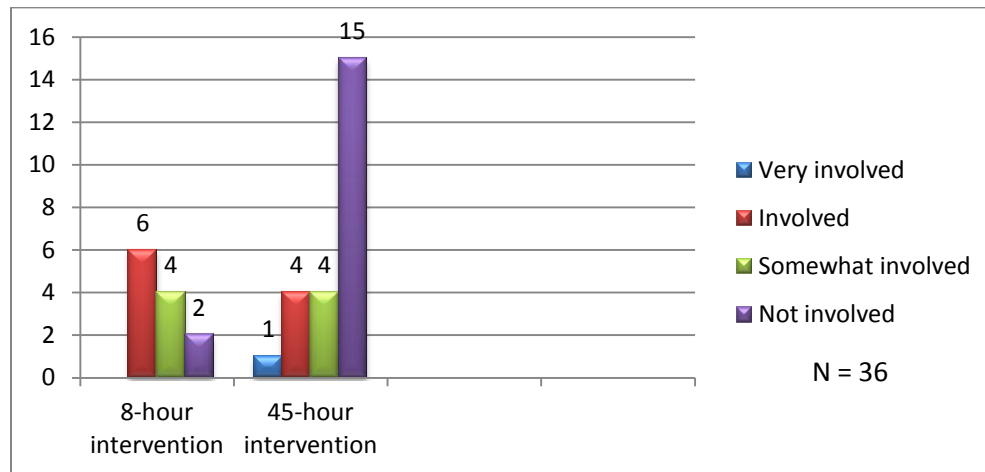
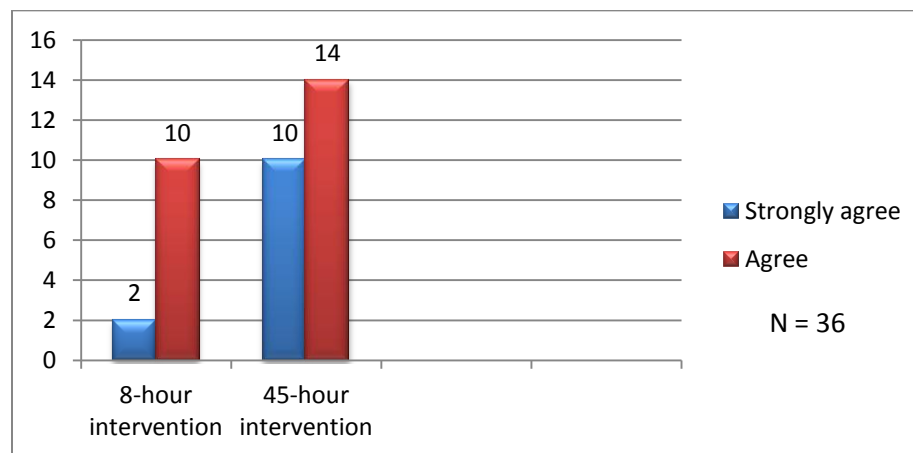


Figure 12. Reported Involvement with Other Ethnicities Outside the Health Care Setting by Intervention Group



All students strongly agreed or agreed that becoming CC is something a practitioner must “want to” achieve (Figure 13).

Figure 13. Reported Belief that One Must “Want to” Become Culturally Competent by Intervention Group

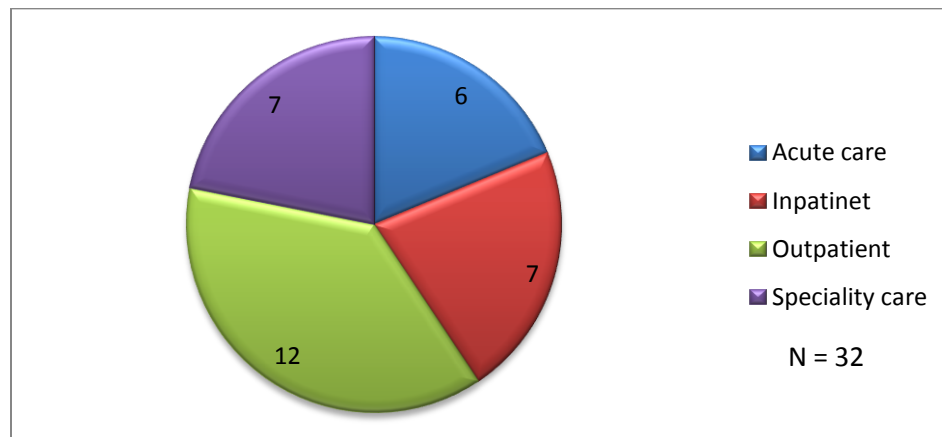


Clinical Observations

I conducted 32 clinical observations in four different facility settings (Figure 14) to learn how students use anthropologically based CC skills in clinical practice. I wanted to see *if* students showed motivation to apply CC education in clinical practice, *how* they used CC

education during clinical encounters, and *which* specific elements of CC education were most useful and relevant to physical therapy practice.

Figure 14. Clinical Observations Facility by Type



The majority of the clinical observations (90.6%, $n = 29$) did not involve new patients, therefore, I rarely observed PTs conducting an initial assessment. During 19 (59%) observations PTs talked only to patients about the technical aspects of their care. At 12 observations (37.5%) PTs talked to patients about the technical aspects of their care and about patient perspective of their condition. Five patients (15.6%) disagreed with their physical therapist (PT) about the cause of their illness or their treatment process, and in only two observations (6.2%) did the PT acknowledge the difference and attempt to address the incongruence.

Twenty-one patients (65.6%) were encouraged to direct their own care at some point during the therapy session. A PT never discouraged a patient from asking questions, directing care, or making suggestions for the physical therapy plan. In seven observations (21.9%) PTs acknowledged they had limited knowledge for dealing with a patient's concerns and during 14 observations (43.8%) PTs negotiated the care process. Negotiations included changing therapy

expectations based on patient's concerns or expressive pain, shifting clinical narratives to coexist with patient's goals, and altering therapy techniques.

Key-informant Interview Results

I interviewed students (N = 20) to determine if their perceptions were consistent with the clinical observations and survey results and to learn which elements of cultural competency education were most valuable (eight-hour intervention n = 6, 45-hour intervention n = 14). The first level of analysis involved extracting experiences from the narratives. The following show the individual experiences of the participants related to the research questions. Examples were selected to show the variety of feelings reported in the interviews that I narrowed by eliminating similar feelings. Table 3 lists examples of 30 feelings about using CC in the clinic taken from the 82 original word strings.

Table 3
Individual Feelings about Using Cultural Competency in the Clinic

1. it's absolutely appropriate
2. necessary
3. positive
4. it's needed
5. otherwise hard to relate to populations
6. very important
7. great idea
8. great to know what culture is
9. create a better therapy environment
10. helps patients relax
11. know where patients come from
12. the more competent, the better understanding of variation
13. makes better clinician
14. important in bigger cities
15. provides knowledge for working with patients
16. important with diverse groups
17. really important
18. it's easier when you know what they may or may not like
19. it depends where you are
20. I feel kind of similar to most patients
21. I haven't seen a lot of culture

22. I haven't had the opportunity to utilize it
 23. people respond differently
 24. it helps you increase your rapport with patients
 25. it helps with better outcomes
 26. it's more how to deal with people
 27. so that you don't get good outcome of them because you are in conflict that's not even physical therapy related
 28. it's important to know that everybody is not like you
 29. it's important to be sensitive to the differences and perception
 30. it's an essential skill
-

Examples of feelings about conducting cultural assessment taken from the 80 original word strings are presented in Table 4.

Table 4
Individual Feelings about Conducting Cultural Assessment on All Patients

1. suspend if treating a patient similar
2. when somebody clearly is not white European descent
3. think it's a good thing
4. it's not the first thing I think about
5. when not making progress
6. could be important
7. could provide some good data
8. could also present some challenges with productivity
9. would take time
10. needs to be efficient
11. I don't feel that it's appropriate for all patients
12. depends on the setting
13. appropriate when I'm not very familiar with the culture
14. don't know if everybody would answer the questions
15. they might find it too personal
16. they seem to have distrust with personal questions
17. I don't know how it would be received
18. would be helpful in areas with a lot of cultural diversity
19. just because someone looks like they would have the same culture don't mean they do
20. it would be a good tool to use just so you are aware of any differences
21. if it's a patient you are not really connecting with, not understanding
22. that would be really hard
23. visually without asking there's a lot we can do
24. I would use it if it were available
25. on all patients it might be kind of difficult because most have the same background as provider
26. I don't think it would take much more time
27. get's looked over because you are busy

28. you have to try and fit so much in that first visit
 29. it would probably get more accomplished
 30. I don't think it would be a good idea with some patients
 31. most don't realize they are a different culture such as mine
 32. it would be difficult to define how you're going to assess that because it's a broad area
 33. I don't know how you're going to assess it
 34. it would be difficult to come up with a standard way or set of question that you could ask a group or person
 35. it would take up additional time that may be unnecessary depending on the purpose of the treatment
 36. I think it's a judgment call based on the population you're serving
-

Examples of feelings about specific elements of CC education that were most useful taken from the 67 original word strings are presented in Table 5.

Table 5
Individual Experiences about Usefulness of Cultural Competency Education

1. direct application of it to health care was powerful, important
2. that is does affect your outcomes
3. lots of people think it doesn't matter
4. I think is does matter how much you know about what their beliefs are about their body
5. I feel like it's almost a skill that can't be developed
6. I'm more aware of asking some of those questions
7. it's a huge awakening to be more mindful
8. attitude of openness
9. not something that should be intimidating
10. do the best you can to understand where that person is coming from
11. do the best you can to understand what's important to them
12. make more comfortable experience for them
13. being introduced to some cultures
14. different types of ways people live
15. we didn't deal with cultural competency in other classes
16. learning about things you might encounter
17. to recognize that there are difference in how people view medicine
18. to listen to your patient not to just look at them and assume anything
19. get their perspective without any external judgment at all
20. to see that there were different cultures
21. the different ways they view health care
22. culture doesn't just include what you think about someone from a different culture
23. not be judgmental
24. how to communicate with them
25. not everybody has the same value systems or understanding
26. keeping an open mind
27. there is always something you can learn from each patient

28. how different cultures act with pain
 29. it's also about the socio-economic barriers
 30. you have to consider each individual and worldview
 31. what the populations believe about health practices
 32. people's values connected to health, because it affects motivation
-

The next level of analysis involved collapsing and coding individual experiences into common themes (see appendices E and F for full theme development). Participants identified four themes consistently: (1) cultural competency is important to PT practice; (2) cultural competency is tricky to operationalize; (3) clinical application of cultural competency content is necessary; and (4) cultural competency is discordant with clinical education (see Table 4).

Table 6

Recurring Themes about Cultural Competency in Clinical Practice and Education

1. Cultural competency is important to physical therapy practice
 - Culturally competent practice creates good patient relationships and improves outcomes
 - Cultural competency helps providers better understand patient perspective
 - Cultural competency is unnecessary when patients and providers are similar
 2. Cultural competency is tricky to operationalize
 - Providers have difficulty "knowing" culture
 - Language fluency and communication create uncertainty
 - Time constrains ability to learn about patient worldview
 - Limited exposure to "diverse" patients prevents opportunities for application
 - Providers lack confidence in asking questions about worldview
 3. Clinical application of cultural competency content is necessary
 - Negotiation and patient-centered care already are central to physical therapy practice
 - Providers need opportunities to interact with diverse populations
 4. Cultural competency is discordant with clinical education
 - Introduction to cultural competency is more appropriate during undergraduate study
 - Cultural competency content should be a pre-program requirement
-

Cultural competency is important to PT practice

All students said that cultural competency was an important aspect of providing quality physical therapy, but fewer thought it essential to every patient interaction. Most thought it was

valuable for developing patient rapport and for better understanding a patient's worldview. One student described its importance for both the patient and the provider.

I think it makes patients feel more comfortable and I guess it would make me feel more comfortable if we could come to more of an understanding of each other.

Another student supported the importance of CC education for optimizing therapy and improving patient outcomes.

It's incredibly important just because you meet so many people from different backgrounds and you don't want to offend people. It's a good idea to know where they are coming from too. You can meet in a mutual ground and work from there instead of having barriers to learning or working with that person, so you don't get good outcomes because you are in conflict over something that's not even physical-therapy related.

Several students said CC wasn't crucial to all patient interactions and only was important when serving patients they *thought* were from cultures different from their own. The patients students classified as "other" included those who weren't white, spoke a language other than English, or appeared "physically different." Students more often than not saw CC as conditional and dependent upon setting.

I think it would be helpful especially in the area where there was a lot of cultural diversity. In Dallas, there were definitely different cultural groups. Here I haven't seen as much diversity as I had in that clinic, so it would depend on the clinic. Then I think it would be very helpful.

I don't feel that it's appropriate for all patients depending on what setting you're working in. You might have a patient population where it's very similar.

I think that for most patients it might be kind of difficult just because there are many that have the same background as you or they're used to the culture that we're all used to.

With some patients that I've seen, I don't think it would be as good of an idea. Some of them are typical Caucasian average family, average income.

Being culturally competent was rarely thought of as an ongoing activity. Students considered cultural assessment a default measure used when patients failed to progress or a tool applied

equally to each patient at their first appointment. For example, students continually referenced conducting cultural assessment as if it were a standardized set of questions:

I think it could be important, it could provide some good data, but there are already a lot of paper work things and it would just take time.

I would use it if it were available. I don't know how to go about getting it or including it.

Other students wanted a CC questionnaire to be used as a standardized tool in the clinic.

What tools do I need to have in place to encounter these people and in what setting I'm going to be in and what should I do with these tools? I think a standardized tool could be of use. It at least gives you something to go off of. I do believe that would be helpful for me.

Cultural competency is tricky to operationalize

Physical therapy students had difficulty identifying or "knowing" a patient's culture and were unprepared to respond to differing patient worldviews.

I think what's tough about it is you do see a variety of patients, and it's tough, you're obviously not going to know everything about every culture.

You never know what you're going to encounter or how often you're going to have encounters where you would need to be culturally competent. So I think it's hard to predict that unless you know for sure that the area you're going to or the area you're working in is going to have a higher incidence of people with needs that would have some sort of cultural element.

Another student insightfully stated she was less certain about responding to culture as a result of taking 45 hours of coursework in cultural competency:

I don't know how you teach somebody to be sensitive to that sort of thing or recognize culture because you may not even realize that's what it is because you can't teach everybody's culture. [I think the challenge is] defining what cultural competency is, especially after taking the class.

One student talked about the challenge of treating patients from cultures within cultures,

You go through it so quick that sometimes then you start getting them all combined or especially working here, we work with a lot of Mennonites and so relating to the different types gets a little hairy at times.

Many students said they were concerned with issues of language fluency. Students said they rarely had the opportunity to develop skill in working with patients with language barriers.

The biggest challenges I've had so far is just the communication skills. We do have translators, at least for the Hispanic populations and the Somali populations. Translators are great but at the same time you don't get that true connection with that patient.

I think it's going to be language [as the greatest challenge] for me. I'm going to be interacting with families that speak a hundred different languages. I can't possibly learn all that. So, I'm going to have to figure out how to get around that barrier. That's going to be a big thing and you can't have a translator there all the time.

Some students wished they could speak a foreign language. One student said she wanted to learn Spanish just to be able to communicate with and better understand patients; another said she wished she hadn't rebelled against learning Spanish as a child because it would have been to helpful to her practice.

Students said that the design of a clinical visit – the narrative structure, standards, and regulation of practice – limited their ability to be culturally competent with all patients. These requirements created time constraints that pressured engagement with patients. Being culturally competent is something students perceived as taking effort beyond practicing the skill of physical therapy. When students were asked what kinds of things happen to prevent them from being culturally competent, they said:

The time of course is probably the biggest thing. Obviously you've got to be productive and you've got to be patient and you've got to stay on time and all those things and I guess at times it can be easy just to kind of focus back on the pathology and treat the impairments rather than focusing on the individual.

I would say time restraints, because yes, it should be done initially, but we only have a certain amount of time and as soon as you see that person you do a quick overview, observe the person, their interactions and then later down the line, if we need to look more into their cultural background, then we do, because you don't have that time to be able to do it.

At larger hospitals, it's in and out, the patient doesn't want to do it, you make him do it anyway, [there's] not a lot of talking or relating to the patient, it's almost like an assembly line which is very unfortunate. So, there's no time, especially being a student you're kind [*sic*] shy to ask those types [cultural competency] of questions or to go there, plus we're all really nervous already about what we are supposed to be doing.

Probably time, I think it's kind of a huge downfall. You want to work with patients and get exercises and get to know what they are like. You want to make a connection and spend more time, but there are those standards that you have to meet.

Students also thought that limited exposure to diverse populations during their education and clinical rotations made CC difficult to operationalize. Many students said they wished they had the opportunity to practice their therapy skills with diverse populations, but the experience never happened. PT students are not required to complete each of their rotations in Sedgwick County, Kansas, but most do, resulting in a mostly monocultural, white population of patients. One student said,

I just haven't had a lot of experience and I think that's kind of where you can learn about all these things. Until I actually get put into practice it's kind of hard, I just haven't had a lot of exposure to a huge variety of different cultures.

Lack of confidence was a recurring theme making CC tricky to operationalize. Issues of confidence were most commonly related to limited knowledge to engage in CC care and concerns with upsetting patients. One student said "being a student you are kind of shy to ask those types of questions or to go there." Others said:

You want to be sensitive, but not overly so and not scared to do something just because you think it's going to offend [a patient].

If you don't have as much practice working with certain populations I think to a degree, you can find yourself in a situation where you're a little uncertain with how you're going to handle that and also if you've got a family in there and you walk into that and you're not completely sure of how you're going to handle that situation, I think your confidence as a practitioner [is challenged].

Another student was concerned with the risk of conducting worldview assessment in the presence of clinical instructors who are evaluating clinical skill, not students' ability to apply CC content.

I feel like I am answering to the clinical instructors who have more experience than me in the clinic or in the setting and who are responsible for my grade and who I don't really want to go up against and say, "wait, let's not do it that way."

Clinical application of cultural competency content is necessary

Negotiation of care is central to PT practice and this was supported by the interview data. Students overall said that it's the responsibility of the provider to allow patients control of their physical therapy. When I asked students about their feelings related to negotiation, some said it made them uncomfortable, but most accepted negotiation as long as it didn't ethically conflict with the standards of PT practice. For example:

I think negotiation happens often anyways, and you know you don't always get to do what you want with the patient, not necessarily what you think is best for them, but in the end, I think quality of life is most important.

You negotiate care with patients every day, whatever their cultural background. You have to figure out a way to convince them and work with them so that they understand what they're doing. That's a daily thing that goes on.

You mean having to give a little bit to their way of thinking? I have absolutely no problem with that. I don't think my way is right. I think what they believe in is going to go a long way to helping them get better.

Some students supported negotiation but said it presents its own set of challenges and occasionally can be a contentious process;

Sometimes there is a struggle and you have to rephrase words and adapt your treatment to how you know the patient will be receptive. Sometimes we just won't go a certain direction in our treatment sessions because we know a patient won't be receptive.

That would probably be a little bit stressful, negotiations to find middle ground as to what the treatment is going to be, and a little frustrating. You just have to respect what the patient wants and what they feel is important at the end of the day.

Negotiate care with patients? I feel like you have to do that sometimes anyway. A lot of times you do because not everyone is going to appreciate physical therapy like we do, and a lot of it is learning to cooperate with each other and finding a common ground.

It comes with the job. I mean my views aren't always the best and if my patient doesn't want to be placed in a certain position or be touched in a certain way, they're entitled to their own feelings and control of their own body.

I think it's very doable and sometimes necessary in order to provide the patient the best treatment that's possible even though they may believe that something else may be better for them.

Cultural competency is discordant with clinical education

Students helped me understand that classroom-only cultural competency education is discordant with clinical education expectations. When I asked students what additional cultural competency skills they *wished* they had, many thought additional knowledge of cultural behaviors and beliefs would improve their ability to practice as physical therapists. For example,

You'd love to have a general knowledge of lots of different things, but where to get that is so hard and then, I don't know if you could have all of that.

Maybe a broader knowledge of what is out there and available and more, I guess more ways to understand where people are coming from too.

Just more knowledge about it, it's going to be hard, because every culture is different, but I like knowing more.

I think I do a good job just being sensitive to other cultures; however I wish I were more familiar with different types of cultures. I am becoming more familiar; however I wish I were more familiar with this.

But more specific was student's desires to have better opportunities to apply or practice being culturally competent and learn the kinds of questions they could ask patients that could elicit a better understanding of their worldview. These skills were obviously missing in the clinical experience as demonstrated by these testimonies:

I guess a little bit more training just in having those conversations, what types of questions to ask and then maybe just a little more specific knowledge of minority groups [we will encounter] in the clinic.

I do wish I felt more comfortable asking cultural questions when evaluating a patient because I do think that would help a lot with how you approach them.

The challenge is overall awareness of that person's culture as they see it, what they think is appropriate, what they think is the right thing versus the wrong thing, what their comfort level is, because I think we all assume that everybody is okay if we touch their feet or everybody is okay if we just touch them on the back or look them in the eye. I think I am more aware of people since I've taken the class at school, but I really don't know how to apply it very well. If somebody came in and they were completely diverse from anybody I've treated, I would try to make myself aware of that. I don't know what to ask, I don't really know what I should say.

The best thing would have been to [learn how to ask those questions], because I have come across in [worldview differences] and I don't know how to go any further than, this is the human body and this is what you need, but then how to address the cultural barrier, I'm not really sure.

I asked students how CC education could be enhanced and they overwhelmingly responded that hands-on experience would make cultural competency education more relevant to them as students and more in line with clinical education. They also suggested that increasing clinical case studies would improve their understanding of how to apply CC:

I think more exposure [and] to decrease book work and try to increase experience actually out there experiencing the culture instead of reading about them.

Incorporating culture somehow to what we see in the clinic, and not including stuff that doesn't have [clinical relevance]. When we learn about it in class we aren't thinking that way [and it needs to be tied] into what we do on an everyday basis.

We've learnt the facts as they're stated. Now, how do I apply that person-to-person? Even just going somewhere we can see that interaction, like going to a hospital that has a ton of different cultural diversity and just seeing how it works. I think we just need more hands-on.

Just more life situations or examples of what we might encounter in the clinic and ways to act, to hone in on that and deal with those types of different situations.

I would back just the communication, just training and having those dialogues with patients and how to get the appropriate information from them in a respectful manner.

I think what would make it really interesting would be more personal stories, like people telling of their experience like the book that we read. Real people, if they'd be willing, case study work too.

The last theme to emerge related to CC practice and education is that students thought general cultural competency education might better serve them as a pre-program requirement. They said that undergraduate education in cultural competency or experiences that demonstrated exposure to diverse populations, such as medical mission work, would create a stronger commitment to serving diverse populations and less educational pressure during the clinical phase of learning. Two students pointed out that,

I would like to see it, if it isn't already becoming part of undergraduate [coursework], so that it's not a bombshell when you get into a graduate program where you are really starting to focus. It was helpful [*sic*] but it would have been a little bit easier if there is already some foundational stuff when you get into a graduate program. [Graduate school] maybe isn't the right time for foundation work.

I almost think, and again some people probably wouldn't like this, but I almost think you should have either a minor or at least some previous experience with language of some sort or cultural class before [becoming a PT].

CHAPTER SIX

The Effect of Cultural Competency on Student Attitudes and Motivation

Educators, and anthropologist, often define culture as a shared system of knowledge about life that is learned and passed from one generation to the next. Clinical students are expected to internalize the concept of culture into a quantifiable, recognizable set of patient behaviors that can be managed with clinical skill. To do so relies on the notion that culture is a knowable, constant reality rather than an intangible construct that itself is arbitrarily contrived. Learning technical skills is the cerebral *hard* focus of physical therapy education. Anthropologically based cultural competency is perceived as emotionally *soft* and can do little to compete with the demands of technically and clinically focused program formats. Educational programs translate this further in required clinical rotations by asking supervising clinical instructors to evaluate students based on application of clinical skill, with little or no mention of CC. To expect evaluation of student's application of CC would be an unfair qualification for most clinical instructors since they rarely have had the educational preparation themselves. Furthermore, my attempt to measure CC application through clinical observations yielded no measurable, observable facts by which I could say a student was or was not culturally competent.

Cultural competency education is associated with a positive attitude and increased motivation toward its use in clinical practice. Students reported personal commitment and motivation to care for clients from culturally and ethnically diverse groups. Using CC in the clinic also was reported as "important" through key-informant interviews. Students believed CC contributed to improved health outcomes in populations and that it was "an essential skill." The variables that appear to decrease student motivation include formulaic requirements of the

clinical encounter that challenge conducting cultural assessment on all patients, knowledge limitations, lack of experience with treating diverse populations, concern with offending patients, and cross-cultural communication and language issues.

Students are motivated to question patients about worldview, but they don't perceive they have time to do so given the amount of technical information that must be acted upon during standard appointment. Furthermore, when asked "What are your feelings about conducting cultural assessment on all patients?" I was astounded to learn students thought cultural assessment was some type of written questionnaire rather than an ongoing process of communicating with patients. Informants said, "I think it would be a good tool to use just so you are aware of any differences," that "it would be helpful," and "I would use it if it were available." They thought of learning about culture as a standard set of questions that could be administered at a patient's initial assessment rather than a fluid and ongoing exchange of information.

Graduate clinical students have very little tolerance for generalized information they do not think is directly relevant to practice. One informant said it best, "I would say time is the big factor because of the intensity of the education that we're getting right now and the essential nature of most of the basic functional skills that we need to have to be able to practice." Cultural competency is not essential to clinical practice for most students. I do support recommendations (Panzarella and Matteliano 2008) to integrate applied CC across the PT curriculum rather than have it exist as stand-alone content, but it remains problematic to expect clinical faculty without specialized knowledge of culture to take on additional content and expertise in an already stressed schedule. Introductory content in CC will likely remain an area of expertise for one or a handful of faculty depending on the size of the program. What must change is the timing for

introductory content and how content is integrated and evaluated. Cultural competency content is often introduced during the first of three years in the DPT curriculum (which is the case at WSU). First year PT students may not develop value from introductory CC when there is tremendous stress to memorize technical information once inducted into clinical education. One student said:

I think if you didn't take any sort of cultural courses or get any sort of cultural education prior to graduate school, I don't know if that's a value even though it should be. I think those of us that had some exposure prior to getting where we are now think it's a little bit more of a value, a little bit more of something we pay attention to [more] than people who didn't have anything to do with that before coming. So I think a lot of it is connected to value and a lot of it is connected to time.

Furthermore, first-year students rarely have experiences that reveal the importance of CC in context. Most PT students have never worked in health services prior to graduate study and have little or no point of reference when being taught about clinical application of cultural competency (over 90% of the students in this research had no clinical experience prior to entry in the DPT program at WSU). For these reasons, physical therapy programs could benefit from requiring pre-program demonstration of cultural competency, through formal education or cross-cultural encounters, or wait until the second year and after a minimum of one clinical rotation has occurred to begin introductory CC education for graduate students.

Perhaps most critical is better integration of CC education and evaluation across the curriculum. We must create better ways to evaluate students CC *thinking* during clinical rotations rather than believing CC can be reduced to demonstrable technical skills. Multiple students confessed that my observation at their clinical site influenced them to “think more” about the implication of culture for their patients. One student casually remarked that she hadn't thought about the application of CC in practice until the days before my planned visit. After

reflecting on what she learned at WSU to improve patients' experiences, the student determined there was room for improvement in the way pain evaluations were constructed and by reducing stereotypes about the primarily Mennonite population she served. These reflections and resulting actions are exactly the types of outcomes I hope to see as a result of CC education because being responsive to diverse patient needs is dependent upon attitude more than demonstrable skill. Therefore, educational outcome evaluation should include direct student observation with feedback and discussion by culture theory experts or the use of reflective journaling aimed at improving critical thinking about CC during students' clinical rotations.

CHAPTER SEVEN

Cultural Competency in the Patient Assessment and Treatment Process

Physical therapy students want to know patients as more than their diagnosis.

Unfortunately, the demands of the curriculum and clinical rotations do not allow time for students to develop skill in assessing patients' illness experience. If time were built into the clinical education process for students to practice this type of assessment, it wouldn't translate into clinical reality for a newly minted PT. One student described the challenge of being competent while providing time-constrained pediatric home-based services for a poor family:

That mom I talked about, she just wants to love her baby, which is fine, babies are supposed to be loved. But when you are not making [the baby] work, she is going to depend on you forever, and that makes being culturally competent really difficult because I just want to say put the baby on the floor, let her be on her belly, let her cry and that's just going to totally devastate the mom. It is hard in that situation to be culturally competent, to be careful with your words to somebody like that and not hurt their feelings, but still get your job done.

While most participants said that cultural assessment should be a set of questions administered at the first clinical encounter, I witnessed quite the opposite. Many participants (40% of the clinical observations) subtly assessed patients as an ongoing process. Simple introductory questions like "did you do anything fun this weekend?" "what's your favorite food?" "did you celebrate the 4th of July?" or "do you have family in Wichita" led the way for more intimate conversations that revealed much about a patient's biosocial relationships. Fascinating was students' use of personal information to shape, make relevant, and individualize the therapy process. For example, I watched a PT develop an exercise program that molded her patient's occupational tasks as a farmer into therapy. It was inspiring to witness as this particular patient was failing to improve because he didn't consider the minimal activities of physical therapy

worthwhile “exercise” when compared to his farm chores. The PT creatively altered the perception of the patient, through his own direction, by transforming the therapeutic process to coexist with his embodiment of his injury. She negotiated exercises that emulated the patient’s daily tasks by asking him to show how he used his arms and hands in farming. The PT then named the exercises after farm tasks (i.e., mending fence, greasing zerks) and effectively demonstrated the importance of therapy outcomes to the farmer’s livelihood. This type of patient-directed care was the norm for 70% of the clinical observations, and I never witnessed a patient’s direction discouraged. I’ve come to understand negotiation of care as a cornerstone of physical therapy practice that is reinforced at multiple points in the educational process.

Overt negotiations occurred when patients resisted therapeutic instructions, were in danger of hurting themselves, or were demanding when experiencing pain. More passive negotiations occur when PTs taught patients to use what they had in their homes as therapy tools. For example, I observed care provided to a confident, yet incredibly vulnerable (because of the added insult of a methicillin-resistant *Staphylococcus aureus* (MRSA) infection) older female in the hospital. She was a German immigrant with limited English-speaking skill. Sadly, a translator was never consulted or considered in her care plan; it was her responsibility to understand. I didn’t know the circumstances that led to her hospitalization or her physical therapy treatment plan, but she needed much help. Luckily she was in a regional community hospital where I often observed PTs taking more time with patients (not that they *had* more time, but that they *took* more time because usually they knew the patients, as was this case). The patient said she didn’t want to use her walker when the in-room therapy session began. She wanted her chair repositioned so she could manage the assigned tasks by herself. One of the PTs attempted to force her feet in upward position and patient adamantly demanded “No, I will not

do that!” So the discussion turned to the patient’s home environment and how to use chairs safely and the patient suggested doing another, simpler exercise, with which the PTs complied. The PTs knew the patient must successfully demonstrate required, more difficult tasks as a prerequisite to going home, but allowed the patient control in directing her own care. In cases like this, there is a fine line between honoring patients’ concerns, allowing patients’ control during the very uncontrollable moment of sickness, and moving them toward health. Physical therapists manage these grey areas very well.

The skill of physical therapy is the knowledge of best practices, or the rudimentary movements that can create better mobility. More difficult is the art of physical therapy, which requires PTs to have an attitude of appreciation for each patient’s perspective and desire to respond to differing motives for health. For example, I observed a semi-professional soccer player who likely would never play again because of his serious injury. The patient had complete emotional breakdowns at several previous therapy sessions. This was not part of physical therapists’ training; they were ill-equipped and visibly uncomfortable when working through this patient’s outbursts. He was charted as noncompliant because there was no other standard for recording his lack of progress even though everyone in the clinic knew his back story and rightfully understood his frustration. The PTs worked as a team to provide the patient’s care (I assumed this provided a better sense of security when working with really difficult patients), and responded well to an overt degree of patient directedness. It wasn’t this patient’s first physical therapy. He knew the terminology, he knew process, and he knew he had complete control of the appointment. The PTs allowed him to determine ordering and duration of tasks, and they adapted their process to the confidence and demands of the patient. In 56.30% of observed clinical interactions PTs engaged in similar types of negotiation, and in 22.60% of

my observations, they acknowledged differences between patient and provider worldview as part of the clinical process. Most PTs accepted this as part of the process for successful patient outcomes and these observations were supported by student interview responses. When I asked students how they dealt with differences in explanatory models, nearly all said that “therapy must be patient-driven” and that PTs might need to “play with the structure a little bit to include people’s beliefs.” Honoring worldview and preserving patient dignity were demonstrated as core values to providing care and represent a positive approach for continued reinforcement in CC education for PT students.

Largely unappreciated is how draining it is for PTs to accommodate and adjust to patient differences while still providing the technical aspects of clinical care. One student from the 45-hour intervention group insightfully noted that “I constantly have to almost adapt my personality and my reactions to someone over a longer period of time and that’s kind of tiring. I’m noticing [I] have to constantly adapt to everybody’s single personality to make them feel comfortable and that to me is hard.” Confidence with asking questions about patient worldview varied from one PT to the next, but most *wanted* to get to know their patients. Physical therapists who place value in worldview assessment will include it in their approach to patients. For many this may require years of practice to develop the ease to do so without constant worry of offending patients or falling behind on workload.

Students accepted culturally competent *practice* as an aptitude they would develop **after** they had successfully completed their clinical demonstrations of expertise. For example, one student said,

You never know what you’re going to encounter or how often you’re going to have encounters where you would need to be culturally competent or use those kinds of skills. I think it really depends on your location and based on my short

experience what I've seen so rare in some places I get pretty frequent opportunities to interact with people of different cultures or where I need to use different considerations so to speak, and I've been in others where I have very rare – it's very rare for me to encounter that. So I think it's hard to predict that unless you know for sure that the area you're going to or the area you're working in is going to have a higher incidence of people with needs that would have some sort of culture characteristic that you would need to adapt to or respond to.

This student continued that perhaps it was wasteful in the educational process to learn too much about cultural perceptions of health and illness because it might not directly translate to a PTs future clinical practice. Others agreed that it would be better to wait until job placement for learning about culture to better gauge the common patient population.

When I asked students how they chose patients to be culturally assessed, they said it was based on how patients looked and presented themselves. Physical therapists' CC probing kicked in if a patient didn't speak English, had a name that appeared to be foreign, or was wearing clothing that seemed out-of-place. They didn't think patients required culturally competent care if they looked and sounded similar to the provider. These comments concerned me. Students clearly saw culture as the characteristics of "others." These characteristics do not have one governing similarity, but rather massive overlapping, making their categorization useless and students' belief in their skill to respond futile. When practitioners internalize culture as somehow knowable, it becomes a sloppy generalization when applied to patients. I was warned that "I wouldn't find any culture" by an experienced clinical instructor when preparing for observation at a rural regional hospital. That observation included the 80-year-old German-speaking immigrant, a low-income, low-literacy patient recovering from invasive knee surgery who was being sent home from the hospital without social or financial support, and an elderly patient with dementia who was receiving treatment after being injured in a fist fight over a

woman at his residential long-term care facility. These storylines weren't perceived as "culture" when they occurred among white patients being served by white providers.

Impeded treatment also caused students to culturally assess patients. If a patient wasn't progressing with treatment or was noncompliant, PTs would ask questions to flesh out a cultural cause. If PTs reached an impasse with a patient "believed to be cultural," they rarely asked the patient to inform their thinking or used written materials or resources from their CC course. When incongruence occurred, PTs first asked a coworker for advice, followed by using other resources such as the Internet, and lastly asked the patient to help inform their thinking. Cultural competency education could be improved by encouraging students to understand that patients are the first and most important experts about themselves. Students need to be given permission to ask patients their perspective, which contradicts clinical education that trains students to be experts.

These beliefs represent consistent problems in CC education – viewing culture as a knowable set of key concepts. Graduate clinical CC education would be improved by expanding students' conception of culture and incorporating it within the context of clinical professionalism and responsibility. Expansion requires engaging students in examining culture theory and discourse, the very tasks they report as unimportant to their education, and then creating an obligation for students to apply theory to practice. The goal is to help future practitioners better appreciate not only skin color and ethnicity as "culture," but also the forces of power structures, the body, economics, age, ability, gender, personhood, orientation, health literacy, agency, and religious perspective in shaping how people define and respond to being sick. For example, physical therapists never commented about or acted on the continued gender bias I witnessed during clinical observations. Gender was not viewed as a variable in CC care despite students'

education of its effect on patients' experiences. At one facility I was told an older, wealthy and educated male patient was noncompliant because he wouldn't wear his sling as ordered. The patient had fallen during his travels to Kansas and had to stay because he wasn't well enough to travel home. The female PT in charge of his therapy had little interaction with the patient, spending most of her time charting comments about his progress, allowing a male PT to do the work. The male PT noticed the patient soiled his chair and had an open sore on his knee that required medical care, so nursing became involved. The female PT disagreed with the nursing staff about the type of medical attention the patient needed, and this also decreased time spent on physical therapy assessment reducing the opportunity for the female PT to learn about the patient. Once therapy resumed, the patient resisted direction from the female PT, and he obviously wanted to direct and have control over his care. He made statements like, "Okay, let's go now," "I'll do another one," and "Let's do it again." The patient also corrected and restated the female PTs instructions with his own like, "That would be the void, the void between the ball and your hand," and broadcast skepticism about the quality of his care. I never witnessed this type of interaction between the patient and his male PTs. Male patients were more commonly frustrated receiving PT care while female patients appeared more at ease with receiving care. Physical therapists never responded to these gender-biased behaviors as areas where they might address cultural issues to improve patient care despite being introduced to the concepts during course.

Some PTs reported their own culture and the structure of biomedicine as constraints on practice. For example, one student said that "sticking to a rigid format and having to use tools" limited his approach to patient care. Another student insightfully reported "just knowing yourself and what you are comfortable with and what you really believe" as the greatest cultural

barrier in providing care. One student uneasily chatted with me after his recorded interview saying that graduate school had been incredibly disappointing for him. He developed a negative feeling about “biomedicine” and became frustrated with how knowledge and rituals are transmitted, how regulation binds provider options, and how everything was driven by financial incentive. These were rich points embedded among more common evidence that students didn’t believe biomedicine operated with its own cultural rules or expectations that shaped patient or practitioner perception of health and illness experience. Educating clinical students to appreciate that medicine is not culture-free remains a daunting task because a commitment to clinical education requires at least some faith that biomedicine is the correct and best way to heal. Teaching students empathy for patients stuck between the intersection of health and culture without reducing it to an algorithm will be ignored as subjective twaddle. The very suggestion that clinical interaction could contribute to disparity in health insults a well-meaning health services work force that believes it’s applying neutral, scientific rules to healing.

Several PTs told me that “I really haven’t been around that many people who are different from me.” They recommended creating points of exposure to diverse peoples as a way to expand CC. Suggested activities included “actually sitting down and interviewing someone that has a different background than what you do,” and “just going somewhere where we can see that interaction.” I observed a student assess a patient based on the standards of her profession under the direction of her clinical instructor. Once the clinical instructor left the assessment room, the student asked the patient “why she thought her muscles changed shape?” which is an excellent question designed to elicit congruence in understanding the patient’s perception of her illness. Unfortunately, experimentation with learning how the patient understood her condition ended as soon as the clinical instructor returned to the room. The challenge is finding ways for

students to practice talking with patients about their worldview in safe, supervised environments where there is limited risk of impairing the therapy process. Lack of real time application of classroom-based theory appears to disadvantage practitioners and likely contributes to decreased motivation to be culturally competent.

Communication and issues of language continually present challenges for monolingual practitioners. Some occur because of structural issues of limited dollars to support certified translators; others reflect lack of provider skill. It is easy to empathize with providers who are pensive when trying to provide care to a patient who speaks a language they don't. We must give students more than rules for using translators; we must allow them time to practice these skills while still in school. The chance to practice with a translator occurred for very few physical therapists during their clinical rotation, and none were provided an opportunity to work with a translator during classroom education. Improving student confidence in patient communication can be addressed in assorted ways, including practice with certified medical translators or use of bilingual standardized patients. Reluctance may be reinforced by costs to programs to secure the use of translators or bilingual standardized patients, but program administrators should appreciate this as a primary vulnerability for those entering the workforce.

CHAPTER EIGHT

The Effect of Eight Hours versus 45 Hours of Cultural Competency Education

The effect of eight hours of CC intervention versus 45 hours of CC intervention produced mixed results. Those in the eight-hour intervention group reported greater personal commitment to caring for diverse populations. I propose two reasons for this result. First, those in the eight-hour intervention were farther along in their education and had completed more clinical rotations than the 45-hour intervention group. This could have created less stress in caring for diverse populations through increased patient exposure. Students farther along in the curriculum may have received other reinforcements for providing culturally competent care as well. Second, those in the eight-hour intervention group reported increased likelihood to interact with other ethnicities outside of health care when compared with students from the 45-hour intervention. Therefore, there may have been a strong selection bias of volunteer interviewees who were more comfortable interacting cross-culturally to begin with among the eight-hour intervention interviewees. The 45-hour intervention group also was less willing to seek interaction with diverse groups to learn about culture. This outcome may be based on these same selection biases, or it could be the result of educational pressures placed on first-year students. Students from the 45-hour intervention group may not imagine time in their schedule to prioritize such interactions.

One of the most important findings of this research is the perception of knowledge differences between intervention groups. The 45-hour intervention group saw themselves as less knowledgeable about worldview differences despite having had more detailed and anthropologically based education on the topic. This outcome is critically important for

formulators of CC guidelines. One of the many challenges to teaching CC is to prevent promoting stereotypes or encouraging inappropriate levels of confidence where providers believe they know all they need about particular ethnic groups. The 45-hour intervention group reported a greater self-awareness of stereotyping beliefs than the eight-hour intervention group, and the effect of a more detailed education and exposure to worldview variations possibly helped students appreciate the sophistication of the disease constructs in populations (see also discussion of “awareness” in Chapter Nine). As a result, the increased exposure may have encouraged students to question the constructs they took for granted as biomedical truth.

Kleinman (2006) writes that a “serious side-effect” of cultural competency is that cultural factors are not always central to a patient’s case and that focusing on patient differences may not improve a clinical outcome. Paying special attention to cultural differences can also be interpreted as intrusive by some patients and can make them feel singled out (ibid.:1675). Two students from the 45-hour intervention group pointed out this challenge to using cultural competency in the clinic:

What’s challenging about it is maybe approaching in initially without feeling like I’m pointing out differences. With one of the patients I asked where she is from, because she wears a head scarf and has a little bit of an accent and she said “Well, I’m from here.” And so, I almost didn’t want to offend her by saying “You are different than me.”

Just knowing who to be careful with and who you feel doesn’t really care, some people understand where they are in the world based on culture and how you are different from then and some people couldn’t care less.

Recognition of clinical authority and domain represents a greater appreciation of how patients may perceive stigma as institutionalized. These two students demonstrated awareness of potential bias and stereotype in the clinical encounter, which represents a more elevated understanding of culture; awareness not demonstrated in student’s responses from the eight-hour

intervention group. This outcome was further supported by the survey data. The 45-hour intervention group was more likely to believe in the importance of conducting cultural assessment on all ethnicities than those exposed to the eight-hour intervention.

It appears that increased contact hours support better understanding of complexity of patient worldview. The trick becomes finding a balance point to exposing students to culture theory while still making the content clinically relevant so it is valued. I've consistently argued that "more is better" in terms of anthropologically based cultural competency education for clinical professionals. I, like others (see Chun 2010), thought that by providing the theory students simply would *understand* its importance, develop a commitment to caring for diverse populations, value all perspectives, and apply CC to clinical practice. I was wrong. More only is better when clinical relevance is explicitly taught.

Clinical education programs have included CC in their curriculum by presenting it as a technical skill which results in crisis when required to provide "evidence" of its effectiveness. Evidence of skill may never exist. The problem lies with how student CC has been evaluated. Program leaders and accreditation bodies must be convinced that evidence of CC outcomes in the clinical curriculum do not fit neatly into traditional methods for evaluation. Standardized tools, such as the IAPCC-R[®] used in this research, should only be part of a student's assessment because we cannot rely on them to fully paint a picture of how students manage patient encounters. These types of tools may tell educators the impact an intervention had on improving a student's awareness of cultural practices or attitudes toward working with patients from various ethnicities, but they do little in evaluating what students do with that knowledge. Qualitative forms of clinical reflection and observation feedback would be more effective in understanding how students are using their education. Didactic, compartmentalized cultural competency

education is likely inappropriate for PT students and a misuse of university resources.

Anthropologically based content appears to be beneficial for physical therapy students at a level greater than eight contact hours when application is emphasized in the classroom and students are held accountable for evaluation in the clinic.

CHAPTER NINE

Aspects of Cultural Competency Most Relevant to Physical Therapy Practice

Students said that application to the health care setting, learning to listen to patients, and learning to be relativistic were valuable content in their CC education. Students in the eight-hour intervention group indicated “awareness” as most important when compared to the more specific “recognition of worldview differences” theme that emerged from the 45-hour intervention group. I actually was quite pleased by some of the student’s comments from the 45-hour intervention group when I asked them “What do you see as the most important things you learned?” They said,

I think the most important thing that I have learned is just to recognize that there are differences in how people view medicine. What I think might be strange – that a person doesn’t want to take a pill to make their pain go away – could be a cultural thing. It’s not necessarily because they’re being stubborn.

I think the biggest thing I learned was to listen to your patient, not to just look at them and assume anything, but to dig deeper and get their perspective on it without any external judgment at all, which is really hard.

I guess that culture doesn’t just include what you think [about] someone from a different country. It can be religious preference, sexual orientation, lifestyle, economic level. I guess when I first thought of culture I really didn’t include all of those things.

I think the most important concept is that it’s not just about “you’re from China, you’re from Africa, you’re from Europe”; it’s also about the socioeconomic barriers, maybe just your immediate family’s living situation, and just knowing that it’s a worldview. [A patient] maybe African American but they may be unlike any other that you’ve ever met, and so you have to consider each individual and what their individual situation and worldview is.

Chun (2010) pointed out that most medical program faculty are supportive of including content on culture in the clinical curriculum; it is the students who put up a fuss (614). Most graduate students feel they already are culturally competent when they enroll in PHS 824 –

Cultural Competency. But this is not the case. On the first day of class, I ask students to “name a question you might ask a patient to learn more about their culture” and “name a way in which a patient’s belief might affect their willingness to take your professional advice.” Rarely do students have a reply as they begin to realize my class may be more than rote content knowledge about racial groups. Other students simply don’t want to take the course because they don’t think they need to be culturally competent, and some just don’t care. Most students from both intervention groups said that the PHS 824 – Cultural Competency class was their first experience learning about the connection between culture and health. The course also was the first clinically applied CC experience, even among those students who had prior courses on culture. For example, one student said,

I used to treat everyone with respect and put myself in their shoes. I didn’t really think about culture and its part in healthcare until your class. It just kind of brought it to the forefront -- that you are going to deal with how to care for people with different backgrounds and it is important to be aware of that because they may take things differently. Your class is kind of a different way to look at things.

So it appears that an anthropologically based approach may present a way of thinking that is important in clinical curriculum despite some student resistance to its content.

Students from both intervention groups felt ill-equipped to provide culturally competent referrals and “hoped” they would be able to get additional CC training once they graduated and were in a practice setting. They wanted to take additional formal continuing education credits in general application of CC as well as to learn more population-specific information based on their patient demographic. Students said they wanted opportunities to advance their CC education after graduation and suggested the APTA Web site, the Internet, and Wichita State University as resources for doing so.

Students noted several specific skills they “wish” they had, including: (1) more general knowledge, (2) being bilingual, (3) better translation skills, (4) more experience in CC, and (5) better skill in asking cultural questions and relating to patients. Increasing general knowledge can come with better targeted education, but will also develop over the time through practice and application. Many students want to fine tune their CC skills once they complete the task of clinical education. This is an area that the APTA could capitalize upon by supporting the development of reliable Web-based CC resources and continuing education for practicing physical therapists.

Bilingual practitioners certainly are at an advantage as long as the patient and provider speak the same language. Some students said that a course in medical Spanish would be helpful, but creating bilingual curricula options likely skirt the root causes of disparity in health care. Physical therapy programs and health services systems could better use resources to: improve systems of care for those who need translation services by consistently providing appropriate, certified services and not relying on family or friends to translate for patients; and increase opportunities for students to develop skill and confidence when interacting with patients who require translation services.

Physical therapists need experience and skill associated with asking worldview questions that will generate the types of information they want to provide the highest level of care. These questions will not come from standardized CC tools administered to patients at the initial encounter, but rather from value placed in the importance of learning about worldview and its relationship to health outcomes, and opportunities to engage with a variety of patients. Creating educational encounters, whether through diverse observation or rotation, use of standardized

patients, or required cultural fieldwork, will increasingly be important for preparing students for their careers.

CHAPTER TEN

Moving Beyond Cultural Competency in the Clinic

“The importance of outcomes research on cultural competence interventions should not be overstated, given that many cultural competence interventions have already been implemented despite the lack of rigorously conductive, definitive outcome studies” (Fortier and Bishop 2003:10). In *Setting the Agenda for Research on Cultural Competence in Health Care*, Fortier and Bishop (2003) call for better linkages between researchers and those trained in cultural theory if we are to understand the complexity of teaching and evaluating CC. This intervention and evaluation demonstrates that it *may* be inappropriate to expect so much from our practitioners – to be technically correct and “culturally competent.” The very idea of creating a CC workforce appears to place too high an expectation on students - that they know a laundry list of cultural beliefs and behaviors and will skillfully provide care based on these facts.

The key to improving quality in health services is instilling openness to new ideas, an appreciation for context and flexibility, and willingness to listen, encourage, and respond to patients’ concerns as a matter of professional responsibility. Promoting curiosity, humility, and respect for all patients will be more successful interventions than teaching about equity for “others.” Some researchers (Saha et al. 2008) have argued that this simply boils down to being attentive and developing good communication skill. I argue that it is more – it is trying to get at the authentic experience of the patient. I agree with Kleinman (2006) that providers should be taught to capture “mini-ethnographies” in the clinic to facilitate appreciation for patient’s lived experiences. Ongoing inquiry and documentation of patient perspective guides providers to learn how patients’ social environment affects and is affected when they are sick. Kleinman

additionally recommends determining if ethnic identity matters to a patient by communicating that “people live their ethnicity differently, that the experience of ethnicity is complicated but important, and that it bears significance in the health-care setting” rather than assuming this knowledge (Kleinman 2006:1674). He also encourages finding out what is at stake for patients when they are sick, reconstructing patient’s illness narrative to understand the cultural meaning underpinning their condition, and critically reflecting on the influence of the biomedical clinical relationship as it plays out in a patient’s care scenario (Kleinman 2006:1674-5). This is not to say that we cannot improve the ways providers interact with patients in certain technical ways, such as through effective use of translations services, but trying to make clinical students into culture experts is counterproductive and places too much the of weight of disparity on them. Through teaching the process of mini-ethnography we can shift student perspective from care that is culturally competent to care that is *culturally informed*.

I also recommend making better use of culture-brokering approaches within health services systems. Culture brokering models approach beliefs and behaviors from the framework of individual worldview, rather than attempting to understand patients in terms of their “culture.” The model uses a three-stage approach to learn a patient’s perception of the problem or the communication issue that’s creating conflict, establish rapport and trust, and conduct follow-up interviews to learn from the process and outcomes. The conceptual model requires no guidelines other than maintaining focus on patient worldview while analyzing and developing a solution to their issue (Jezewski and Sotnick 2001). Culture-brokering has been demonstrated to be useful in rehabilitation care and shows some success in connecting patients with effective services across systems of care. Culture-brokering has successfully addressed a number of population-based health issues such as breast cancer among African American women in Washington, D.C.,

traditional healer and physician partnerships for Hmong populations in California, access to health care for the underserved in Appalachia, and rape prevention for the Yankton Sioux in South Dakota (National Center for Cultural Competence 2004). Teaching cultural brokering to clinicians could balance the interests of cultural-competency educators with the needs of patients, but the model could be expanded to utilize the expertise of medical anthropologists in health services systems. Applied anthropologists have gained expanded roles and respect in many environments not traditionally viewed as fitting. Health care systems could be an important next frontier. Clinicians could be technical experts, and medical anthropologists could serve as liaisons to mediate patient concerns as applied cultural theory experts. Culture brokering currently is underutilized and typically reserved for population health issues. Leaders charged with addressing health disparity should consider applying the model within medical care as a potential approach to improving reflexivity of both patients and providers.

I have incorporated much of this research into my teaching at Wichita State University. It was most important to me to change the way I presented the concept of culture. I do not want students receiving an education that implies culture is knowable. Therefore, I've modified course content and format to teach a process of culturally informed rather than culturally competent care. I changed the 16-week (45-hour) didactic format to 10-weeks (28-hours) in the classroom (see Appendix H, Competencies Addressed: Revised 10-Week Educational Format). I enhanced some content, such as deconstructing biomedicine, describing illness experience, demonstrating negotiation of care, and incorporating cultural brokering. Other content was deleted, including descriptions of health beliefs and behaviors specific to ethnic or racial groups to remove the temptation for students to perceive "culturally competent" care as a way to treat "others." I continue to assign classic anthropological theory readings, but I take special effort to

directly demonstrate how each topic relates to clinical practice through the use of directed case studies (see Appendix I, Sample Case Study on Culturally Informed Care). I added a clinical rotation reflection component to create a steering effect. After 10 weeks of lecture, discussion, and activities, students will complete a set of reflection papers at the end of each week of their summer rotation, beginning 2013. My objectives are for students to apply course content related to (1) understanding patient behavior as more than simple expressions of race and ethnicity, (2) evaluating the constraints of biomedicine, and (3) increasing confidence in talking to patients about how they understand and respond to their illness. Sample reflection topics include:

- Describing ways facilities could be more responsive to the needs of diverse patients;
- Describing how the values of biomedicine are reinforced in rotation facilities and how they contribute positively and negatively to patient care;
- Describing how culturally informed care was provided to a patient during rotation including analysis of what worked and what didn't work;
- Describing how to improve approaches to clinical professionalism and culturally informed care.

Reflection responses will be graded as satisfactory or unsatisfactory. Students will be allowed to complete a new set of reflections during their second rotation if they are unable to demonstrate an understanding and application of course content. In the rare occasion that a second rotation doesn't draw out serious reflection, I will work one-on-one with a student in the clinic by observing, providing feedback, and engaging discussion. These teaching methods will not change the attitudes of all students nor will they help every student understand *how* to respond to patient worldview, but they represent a step forward in how we approach clinical education.

This research demonstrates that anthropological culture theory must not be abandoned in the education of health professionals. We will not make our practitioners better by enabling them to view culture as transparent or fixed. Our goal should be to help practitioners value the thorny complexity of worldview. We must advocate that providers learn *from* patients and appropriately adjust care to compounding cultural intricacies. We must continue experimental ethnographies to determine the best placement for CC education and open a dialog about the very notion of teaching “cultural competency.” I recommend removing the concept from clinical education and moving health professionals to engage in culturally informed care as a general commitment to clinical professionalism. Clinicians must be taught to explore patient worldview as a normal part of every encounter as opposed to a special type of care reserved for people of color. We should insist that students value the care process for ALL patients and hope they pay notice.

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APPENDIX A

Office of Minority Health's Recommended National Standards for Culturally and Linguistically

Appropriate Services (CLAS) in Health Care

The Fundamentals of Culturally Competent Care
<p>Standard 1 Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.</p>
<p>Standard 2 Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.</p>
<p>Standard 3 Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.</p>
Speaking of Culturally Competent Care
<p>Standard 4 Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.</p>
<p>Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</p>
<p>Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).</p>
<p>Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.</p>
Structuring Culturally Competent Care
<p>Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that</p>

outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
<p>Standard 9</p> <p>Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.</p>
<p>Standard 10</p> <p>Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.</p>
<p>Standard 11</p> <p>Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.</p>
<p>Standard 12</p> <p>Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.</p>
<p>Standard 13</p> <p>Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.</p>
<p>Standard 14</p> <p>Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.</p>

Source: Office of Minority Health. <http://minorityhealth.hhs.gov>

APPENDIX B

Survey Assessment

General Demographics & Baseline Cultural Competency Exposure

Please indicate your ethnicity

Please list all languages you speak in addition to English

Please indicate your status in the doctor of physical therapy program at Wichita State University

(please select one)

☐ I graduated in May 2012

☐ I plan to graduate in May 2013

Did you have formal cultural competency education before taking courses in the doctor of physical therapy program Wichita State University? Examples of formal study might include course work in another program or through a workplace setting.

☐ Yes

☐ No

Please list any informal cultural competency education you may have. Examples may include personal experiences or community-based training.

Did you practice as a clinician prior to taking course work in the doctor of physical therapy program at Wichita State University?

☐ Yes

[] No

Inventory for Assessing The Process of Cultural Competence Among Healthcare Professionals –

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APPENDIX C

Clinical Observation Check Sheet

1) Intervention group

☐ 8-hours

☐ 45-hours

2) Facility Type

☐ Acute care

☐ Inpatient

☐ Outpatient

☐ Specialty care

☐ Other _____

3) Type of visit

☐ First visit between patient and provider

☐ Successive visit -- part of care plan, this provider

☐ Successive visit -- part of care plan, multiple providers

☐ First visit return to care

☐ Other _____

4) Translation services

☐ Family member

☐ Bilingual staff member

☐ Certified translator

☐ Cultural broker

☐ Other _____

☐ No translator or interpreter needed

5) Cultural assessment

☐ Yes -- this clinical encounter

☐ Yes -- previous clinical encounter

☐ No

6) Explanatory models

☐ Incongruence addressed

☐ Incongruence NOT addressed

☐ No incongruence observed

7) Patient-directed discussion

☐ Provider encouraged patient-directedness

☐ Provider discouraged patient-directedness

☐ Provider neither encouraged nor discouraged patient-directedness

8) Worldview differences and health perception

☐ Provider acknowledged differences

☐ Provider DID NOT acknowledge differences

☐ No differences observed

9) Did provider acknowledgment any limitation of competence?

☐ Yes

☐ No

10) Did provider engage in negotiation of care?

☐ Yes

☐ No

11) Describe negotiation of care, if operationalized

12) Referrals and community-based services

☐ Provider recommended culturally appropriate referral

☐ Provider recommended culturally appropriate community-based services

☐ Patient did not require referral or other services

13) Type of services recommended

14) Education and/or consultation

☐ Provider sought additional information from patient

☐ Provider sought additional information from co-worker

☐ Provider sought information from another source

☐ Provider DID NOT seek information, congruence was not achieved

☐ Not needed, congruence appeared to be achieved

15) Type of resources consulted

16) General observations

APPENDIX D

Key-Informant Interview Questions

1. What is your status in the doctor of physical therapy program at Wichita State University?
 - a. Graduated May 2012 – 8 hour intervention group
 - b. Plans to graduate May 2013 – 45 hour intervention group
2. What are your feelings about using cultural competency skills in the clinical environment?
 - a. Prompt: positive, negative, neither positive nor negative
3. What are the major challenges in doing so?
4. What are your feelings about conducting cultural assessment on all patients?
 - a. Prompt: regardless of age, ethnicity, race, religion, orientation, ability, gender
5. How do you culturally assess patients?
 - a. Prompt: How do you learn more about a patient's culture?
6. At what point should a provider culturally assess a patient?
7. When did you first learn about the connection between culture and health?
8. Think of the time before you started your formal physical therapy education. Had you gained knowledge of the connection between culture and health before being learning about it in your program of study at Wichita State University (WSU)? If so, can you describe those experiences?
9. Think about your current cultural competency education. What do you see as the most important things you learned? How does this help you in your job?
 - a. Prompt: Can you provide an example?
10. Is there anything in particular that has helped you care for patients?
11. How would you describe cultural competency to others?
12. What kinds of things happen in your job that prevent you from being culturally competent?

13. What are the major cultural challenges in caring for your patients? Do you feel equipped to take on these challenges? Do you feel you are missing educational skills or information for these challenges?
14. What are some of the ways you learn about worldview differences with patients?
 - a. Prompt: Can you provide an example?
15. How do you feel about talking to patients about differences in explanatory models?
 - a. Prompt: patients having a different perception of the cause and nature of their condition when compared to the biomedical explanation
16. What do you do if you have a limited cultural knowledge to provide care to a patient?
17. How do you feel about the possibility of having to negotiate care with a patient? What are the limits to your negotiation?
18. Do you feel you have the knowledge or experience to provide culture-based referrals? If not, what limits you?
19. What do you do if your values or beliefs clash with those of a patient?
20. What additional cultural competency skills do you wish you had?
21. Where could you seek additional education or training in cultural competency?
22. If cultural competency education was enhanced, what do you think should be included?
23. What is the greatest cultural barrier in doing your best for patients?
24. Can you describe a specific situation when you were challenged in serving a patient based on culture? What was the outcome of this situation?
25. Did you observe experienced physical therapists using culturally competent care during your clinical rotations? Was this true for the majority or physical therapists, the minority or somewhere in between? Can you provide an example?

APPENDIX E

Eight-hour Intervention Data Collapse by Question

2. What are your feelings about using cultural competency skills in the clinical environment?

Theme 1

Important (f=5) [003-3793, 008- 4180, 014-4181, 017- 4183, 021- 4184]

Specifics

1. It's absolutely appropriate [001-3793]
2. Great idea [009-4180]
3. Great to know what culture is [010-4180]
4. Create a better therapy environment [011-4180]
5. Helps patients relax [012-4180]
6. Know where patients come from [013-4180]
7. The more competent, the better understanding of differences [015-4181]
8. Make better clinicians [016-4181]
9. Provides knowledge for working with patients [018-4183]
10. Important in urban areas [019-4183]
11. Important to do a good job [021-4184]
12. Important with diverse groups [022-4184]

Theme 2

Positive (f=2) [004-3793, 020-4183]

Other Independent Beliefs

1. Necessary [002-3793]
2. Glad WSU had it [006-4179]
3. It's needed [005-4179]
4. Otherwise hard to relate to populations [007-4179]

3. What are the major challenges in doing so?

Theme 1

Knowledge limitations (f=3) [001-3793, 013-4181, 007-4179]

Specifics

1. Potential conflict [002-3793]
2. Helpful to know prior to engagement [003-3793]
3. Being able to convert into cultural competency [004-3793]
4. Getting them all combined [006-4179]

Theme 2

Adequate education (f=2) [005-4179, 018-4184]

Specifics

1. Eight hours too short [008-4179]
2. Do some in the clinic [009-4179]
3. Hearing is great, but hard to remember [010-4179]

Theme 3

Communication Issues (f=2) [001-4180, 015-4181]

Specifics

1. Translators are great, but you don't get true connection [012-4180]

Other Independent Beliefs

1. Attitude and tolerance most important [014-4181]
2. Try to accommodate different needs based on culture most important [016-4181]

4. What are your feelings about conducting cultural assessment on all patients?

Theme 1

A good thing (f=3) [005-4179, 013-4181, 019-4184]

Specifics

1. Could provide some good data [014-4181]

Theme 2

When there is a cultural gap (f=2) [002-3793, 018-4183]

Theme 3

Unnecessary when treating a patient similar to provider (f=2) [003-3793, 017-4183]

Specifics

1. When treating someone clearly not white European descent [004-3793]

Theme 4

Difficult because of time limitations (f=2) [009-4180, 015-4181]

Specifics

1. Needs to be efficient [016-4181]

Other Independent Beliefs

1. Where there may be a conflict [001-3793]
2. It's not the first thing I think about [006-4179]
3. When not making progress [007-4179]
4. What are the underlying causes [008-4179]
5. Variety of differences with each patient [010-4180]
6. Even with age differences [011-4180]
7. Important to be aware [012-4180]
8. Don't know if everybody would answer the questions [020-4184]
9. They might find it too personal [021-4184]
10. They seem to have distrust with personal questions [22-4184]
11. I don't know how it would be received [23-4184]

5. How do you culturally assess patients?

Theme 1

Observation (f=3) [001-3793, 006-4179, 018-4180]

Specifics

1. How they appear physically [002-3793]
2. Their body stance [003-3793]
3. What they're wearing [007-4179]
4. Their interaction between other people [008-4179]

Theme 2

Language (f=3) [004-3793, 014-4180, 028-4184]

Specifics

1. If they speak English [013-4180]

Theme 3

Patient/ provider interaction (f=3) [009-4179, 012-4180, 020-4181]

Specifics

1. If a patient wants to get in and out quickly [015-4180]
2. Engage them on a more personal level [017-4180]
3. Making sure they are comfortable [21-4181]
4. Making sure you're aware of cultural differences [022-4181]
5. Getting a complete understanding of that individual [023-4181]
6. Understanding what's important to them [024-4181]
7. Understanding how to provide the best care possible [025-4181]

Other Independent Beliefs

1. It isn't about nationality [005-3793]
2. How people fill out pain questionnaires [010-4179]
3. With their name [011-4180]
4. Social aspects of their life [016-4180]
5. Basically what does the race seem to be [027-4184]
6. You can make assumptions as far as culture [029-4184]
7. Without asking, you don't know for sure about differences [030-4184]

No Response

026-4183

6. At what point should a provider culturally assess a patient?

Theme 1

Initial evaluation (f=3) [002-4179, 009-4181, 014-4183]

Specifics

1. When there are obvious differences [012-4181]
2. When there are differences I suspect [013-4181]

Theme 2

Not necessary at each evaluation (f=2) [004-4179, 0111-4181]

Specifics

1. I'm not the best at doing that every time [003-4179]
2. It probably doesn't always happen that way [005-4179]

Theme 3

Before you meet the patient (f=2) 006-4180, 010-4181]

Specifics

1. Not necessarily a judgment, but to prepare for what to expect [007-4180]
2. Any background information is important [008-4180]

Other Independent Beliefs

1. Even after the interaction [015-4183]
2. Reference the internet [016-4183]
3. Talk to someone familiar with that culture [017-4183]
4. If they seem uncomfortable with something [018-4184]
5. Certain things like gender [019-4184]
6. Body language [020-4184]
7. They might insist on some kind of treatment [021-4184]

No Response

001-3793

7. When did you first learn about the connection between culture and health?

Theme 1

Your class (f=2) [001-3793, 019-4184]

Specifics

1. Nothing that we learned on paper surprised me [002-3793]
2. I had never formally had the number [003-3793]

Theme 2

Undergraduate education (f=2) [004-4179, 015-4181]

Specifics

1. I don't know how you put it in practice [005-4179]

Theme 3

Cross-cultural exposure (f=2) [006-4179, 011-4180]

Specifics

1. Friends from Africa [012-4180]
2. Hearing about experiences with health care [013-4180]

Other Independent Beliefs

1. I've always been aware [007-4180]
2. Some people are more blessed with certain things [008-4180]
3. Certain cultures have less health care than we have [009-4180]
4. Started in early middle school [010-4180]
5. During grad school [014-4181]
6. As you get clinical experience [016-4181]
7. Formal study is going to be lacking [017-4181]

8. Think of a time before you started your formal physical therapy education. Had you gained knowledge of the connection between culture and health before learning about it in your program of study at Wichita State University?

Theme 1

Yes (f=6) [001-3793, 003-4179, 006-4180, 010-4181, 014-4183, 018-4184]

Sub-Theme 1

Hands on experience (f=3) [011-4181, 015-4183, 020-4184]

Specifics

1. From working [015-4183]
2. Volunteerism [021-4184]
3. Most of the people I treated didn't speak English [022-4184]
4. I also worked at a nursing home [023-4184]

Sub-Theme 2

As an undergraduate student (f=2) [002-3793, 007-4180]

Specifics

1. Not necessarily cultural competence [008-4180]
2. Maybe health and the differences [009-4180]

Sub-Theme 3

Informal learning (f=2) [010-4181, 019-4184]

Other Independent Beliefs

1. Observing [016-4183]
2. Having conversations [013-4181]
3. Not consciously [016-4183]
4. Putting facts together [017-4183]
5. Keep people's individual rights [024-4184]
6. Keep people's cultural background in mind [025-4184]

9. Think about your current cultural competency education. What do you see as the most important things you learned? How does this help you in our job?

Theme 1

Awareness (f=6) [003-4179, 007-4180, 012-4181, 022-4183, 026-4184, 020-4183]

Specifics

1. That is does affect your outcomes [004-4179]
2. Lots of people think it doesn't matter [005-4179]
3. I think it does matter how much you know about what their beliefs are about their body [006-4179]
4. I am more aware of asking some of those questions [009-3180]
5. It's a huge awakening to be more mindful [011-4180]
6. Attitude of openness [013-4181]
7. People are different [015-4181]
8. Do the best you can to understand where that person is coming from [016-4181]
9. Do the best you can to understand what's important to them [017-4181]

Theme 2

Application to health care/physical therapy (f=2) [001-3793, 025-4184]

Specifics

1. It's important as a healthcare provider to be able to know that [002-3793]
2. Learning about things you might encounter [026-4184]

Other Independent Beliefs

1. I feel like it's almost a skill that can't be developed [008-4180]
2. Population constraints [010-4180]
3. Not something that should be intimidating [014-4181]
4. Making sure people know we care [018-4181]
5. Make more comfortable experience for them [019-4181]
6. Impacts job positively [021-4183]
7. Lectures were most important [023-4184]
8. We didn't deal with cultural competency in other classes [024-4184]
9. Rotations were helpful [027-4184]

10. Is there anything in particular that has helped you care for patients?

Theme 1

General awareness (f=4) [003-4179, 004-4180, 005-4181, 013-4184]

Specifics

1. Being willing to ask questions [006-4181]
2. Open attitude [007-418]
3. To be willing to discuss [008-4181]
4. That I need to read that person's body language [014-4184]
5. Make sure they're comfortable with everything [015-4184]
6. To look at people around me, even coworkers [016-4184]

Other Independent Beliefs

1. Being reminded that I need to allow myself to absorb where somebody is [001-3793]
2. Try to serve them where they can best be served [002-3793]
3. Transgender [009-4183]
4. Gay [010-4183]
5. Lesbian [011-4183]
6. More sensitive to how people are to the subject [012-4183]

11. How would you describe cultural competency to others?

Theme 1

Cultural awareness (f=3) [001-3793, 01=4181, 019-4183]

Specifics

1. Where the person is coming from [003-3793]
2. Awareness of all the differences [005-3793]

Sub-Theme 1

Being respectful (f=2) [002-3793, 013-4180]

Theme 2

Ethnic/lifestyle knowledge (f=2) [007-4179, 020-4183]

Specifics

1. Activities they do [009-4179]
2. How they live [010-4179]
3. Customs [022-4813]

Other Independent Beliefs

1. Allow yourself to be the learner [004-3793]
2. How a group or individual relates to their culture [006-4179]
3. Know cultural barriers [012-4180]
4. Treating them like I would want to be treated [015-4180]
5. Trying to be efficient in interactions [017-4181]
6. Making sure you're providing the best care in accordance with cultural differences [018-4181]

No Response

023-4184

12. What kinds of things happen in your job that prevent you from being culturally competent?

Theme 1

Time constraints (f=3) [004-4179, 010-4181, 013-4183]

Specifics

1. If we need to look into cultural background then we do [005-4179]
2. Focus is on pathology rather than individual [011-4181]
3. You'd rather get objective data [012-4181]

Theme 2

Lack of exposure to diverse populations (f=2) [015-4183, 016-4184]

Other Independent Beliefs

1. Being new at what I do [001-3793]
2. Being tired [002-3793]
3. Challenges that are so far away from what I understand [003-3793]
4. I was already being set up to think things about patients without seeing them [006-4180]
5. It lead me wrong [007-4180]
6. It's a lack of awareness [008-4180]
7. When I don't know the language [009-4180]
8. Jobs won't give you the education [014-4183]

13. What are the major challenges in caring for your patients? Do you feel equipped to take on these challenges? Do you feel you are missing educational skills or information for these challenges?

Theme 1

Language (f=3) [005-4181, 007-4183, 008-4184]

Other Independent Beliefs

1. I am hearing impaired [001-3793]
2. Not doing home exercise programs [002-4179]
3. Clothing [003-4180]
4. Making sure people understand touch [006-4181]
5. I would love to have a class on medical Spanish [009-4181]
6. I think a cultural elective would be wonderful [010-4184]

14. What are some of the ways you learn about worldview differences with patients?

Theme 1

Ask (f=4) [001-3793, 008-4181, 009-4183, 010-4184]

Specifics

1. You've got to be careful [002-3793]

Theme 2

Learn from others (f=2) [004-4179, 006-4180]

Specifics

1. Learn from people that are more culturally aware [007-4180]

Other Independent Beliefs

1. Magazines [003-4179]
2. The internet [005-4179]
3. Research it [011-4184]
4. Try to learn more about it before they come in [012-4184]
5. Interacting with my patients [013-4184]

15. How do you feel about talking to patients about differences in explanatory models?

Theme 1

Haven't experienced it yet (f=3) [008-4180, 009-4181, 014-4184]

Specifics

1. Do some more follow up questions [010-4181]
2. I'm not sure how I'm going to feel about it [015-4184]
3. I think I will be nervous [016-4184]
4. I hope they'll be open to what I have to say [017-4184]
5. I'll try to be open to what they say to me as well [018-4184]

Theme 2

Good (f=2) [002-4179, 011-4183]

Specifics

1. If they question further I feel uncomfortable [005-4179]

Theme 3

I will provide my view (f=2) [007-4180, 012-4183]

Specifics

1. They choose to accept it or not [013-4183]

Other Independent Beliefs

1. It's safe to talk about one of the courses I've had [001-3793]
2. Using less jargon [003-4179]
3. Show them pictures [004-4179]
4. I don't know how to formulate the correct questions [006-4179]

16. What do you do if you have limited cultural knowledge to provide care to a patient?

Theme 1

Ask the questions (f=4) [001-3793, 003-4180, 004-4181, 012-4184]

Theme 2

Talk to other professionals (f=3) [002-4179, 005-4181, 010-4184]

Theme 3

Look on the Internet (f=2) [007-4181, 011-4184]

Other Independent Beliefs

1. Do research [006-4181]
2. Just do the best I can [008-4183]
3. Ask for a translator [009-4183]
4. Read body language [013-4184]

17. How do you feel about the possibility of having to negotiate care with a patient? What are the limits to your negotiation?

Theme 1

Okay with negotiation (f=5) [004-4179, 006-4180, 011-4181, 013-4183, 014-4184]

Specifics

1. My views aren't always the best [007-4180]
2. They're entitled to their own feeling of control [008-4180]
3. You would like a patient to agree [009-4181]
4. There is a give and take [010-4181]
5. It's sometimes necessary to provide the best treatment [012-4183]
6. You have to follow guidelines [015-4184]
7. You have to be flexible [016-4184]
8. Show that their idea are important to me [017-4184]

Other Independent Beliefs

1. Ask can you show me [001-3793]
2. Ask what seems to help for you 002-3793]
3. I can share one of the things we've found in the research that might help [003-3793]

18. Do you feel you have the knowledge or experience to provide culture-based referrals? If no, what limits you?

Theme 1

No (f=2) [002-4179, 005-4181]

Specifics

1. I'd like to know more about that [009-4184]

Theme 2

Yes (f=2) [005-4181, 006-4183]

Specifics

1. I've become more familiar with other cultures [007-4183]

19. What do you do if your values or beliefs clash with those of a patient?

Theme 1

Patients don't need to believe in the same thing as providers (f=6) [001-3793, 005-4179, 010-4180, 012-4181, 015-4183, 017-4184]

Specifics

1. I think that happens often [002-4179]
2. It's hard to address [003-4179]
3. Especially end-of-life care [004-4179]
4. You don't force anything on anybody [006-4179]
5. That's their choice [008-4179]
6. Everybody is different [013-4181]

Sub-Theme 1

I am tolerant (f=2) [007-4179, 016-4184]

Theme 2

Best quality care is most important (f=2) [009-4180, 014-4181]

20. What additional cultural competency skills do you wish you had?

Theme 1

More knowledge of different cultures (f=3) [006-4181, 007-4183, 008-4184]

Theme 2

Better translation-use skills (f=2) [001-3793, 004-4180]

Theme 3

Knowing how to ask culture questions (f=2) [002-4179, 005-4181]

21. Where could you seek additional education or training in cultural competency?

Theme 1

Continuing education or coursework (f=4) [005-3793, 0074180, 012-4191, 016-4184]

Specifics

1. Formal classes [013-4181]

Sub-Theme 1

“Hope” for continuing education or coursework (f=3) [008-4180, 014-4181, 018-4184]

Theme 2

The Internet (f=2) [009-4180, 011-4181]

Theme 3

Written materials (f=2) [02-3793, 022-4184]

No Response

006-4179

015-4183

22. If cultural competency education was enhanced, what do you think should be included?

Independent Beliefs

1. I would like to see it becoming part of under graduate [001-3793]
2. Graduate program isn't the right time for foundation work [002-3793]
3. Observations [003-4179]
4. Expanding on Kansas cultures [004-4180]
5. Training and having those dialogues with patients [005-4181]
6. Course we do have has exposed class [006-4183]

No Response

007-4184

23. What is the greatest cultural barrier in doing your best for patients?

Theme 1

Language issues (f=3) [003-4180, 004-4181, 006-4184]

Other Independent Beliefs

1. When it runs contraindicated to what you need to do to meet service protocols [001-3793]
2. Beliefs towards healthcare [002-4179]
3. I'm not quite sure 005-4183]

25. Did you observe experienced physical therapists using culturally competent care during your clinical rotations? Was this true for the majority of physical therapists, the minority or somewhere in between?

Theme 1

Yes (f=6) [001-3793, 003-4179, 006-4180, 008-4181, 011-4183]

Specifics

1. I don't remember being even hardly aware of it [004-4179]
2. A lot of times that can wait [005-4179]
3. Some are better than others [010-4181]

Sub-Theme 1

Majority (f=4) [002-3793, 009-4181, 012-4183, 014-4184]

Independent Belief

1. Probably 50% were culturally competent [007-4180]

APPENDIX F

45-hour Intervention Data Collapse by Question

2. What are your feelings about using cultural competency in the clinical environment?

Theme 1

Important (f=11) [001-3800, 009-3799, 016-3796, 021-3792, 025-3791, 031-3790, 034-3961, 042-3957, 045-4178, 051-4322, 052-4323]

Specifics

1. Make patients feel more comfortable [002-3800]
2. Would make me feel more comfortable if we could come to more of an understanding of each other [003-3800]
4. Everyone needs them [015-3796]
5. People respond differently [017-3796]
6. It's helped me already [032-3790]
7. Every single time [033-3790]
8. It's important to be sensitive to the differences and perception [046-4178]
9. You need to be sensitive and realize maybe the emotional aspects that people are experiencing [047-4178]
10. Thought it was important before I was in the program [050-4322]
11. It does come up [054-4323]
12. Sometimes you don't even realize it's there [055-4323]

Sub-Theme 1

Good to understand background (f=3) [004-3800, 035-3961, 041-3957]

Specifics

1. It's easier when you know what they may or may not like [005-3800]
2. Don't want to be offending the people [036-3961]
3. It's good to know where they are coming from too [037-3961]
4. You can meet in a mutual ground [038-3961]
5. Work from there instead of having barriers to learning or working with that person [039-3961]
6. I wouldn't have know what it would be like to be around people of Hispanic descent [043-4178]
7. You have to be very careful how you talk with them [044-3957]

Theme 2

Depends on the patient population mix (f=3) [006-3799, 010-3798, 026-3791]

Specifics

1. I feel kind of similar to most patients [008-3799]
2. I haven't had the opportunity to utilize it [012-3798]

Theme 3

Contributes to better outcomes (f=2) [020-3794, 040-3961]

Other Independent Beliefs

1. Really helpful [006-3799]
2. But I can see how the stuff we learned could definitely be beneficial [011-3798]
3. Very applicable [018-3794]
4. It helps you increase your rapport with patients [019-3794]
5. I thought back to your class [022-3792]
6. Different ways of communicating [023-3792]
7. Timeliness is huge [024-3792]
8. Don't think it's so much cultural competency [027-3791]
9. It's more how to deal with people [028-3791]
10. I'm not using specific things [029-3791]
11. It's my overall approach [030-3791]
12. It's an essential skill [048-4322]
13. With the way that our population in the county is changing [049-4322]
14. I can't think of a situation where it's been a huge ordeal [050-4323]
15. Positive [056-4323]

3. What are the major challenges in doing so?

Theme 1

Having enough knowledge of potential differences (f=3) [001-3800, 022-3794, 027-3792]

Specifics

1. Make a few mistakes at first [002-3800]
2. It might take me a while [003-3800]
3. If I knew early on it makes things easier for both of us [004-3800]
4. Not everybody is the same [023-3794]
5. You have to read each patient differently [024-3794]
6. I think that's kind of a skill [025-3794]
7. It's a skill you develop over time [026-3794]

Theme 4

Not offending patients (f=3) [006-3799, 019-3796, 037-3957]

Specifics

1. Approaching it initially without feeling like I'm pointing out differences [005-3799]
2. It's kind of intimidating getting to know what their culture is [007-3799]
3. You're kind of not embarrassed, but shy to ask [017-3796]
4. You don't want to seem like you're crossing the boundaries [018-3796]
5. It is really just asking them in a round off way [020-3796]
6. Some people understand where they are in the world based on culture [038-3957]

Theme 3

Language issues (f=2) [013-3797, 047-4323]

Specifics

1. We got o school then have to learn to simplify what we say [014-3797]
2. How you speak to someone [015-3797]
3. Your stance [016-3797]

Theme 4

Frequency of interactions with different cultures (f=2) [032-3790, 043-4322]

Specifics

1. Most of my observations have been pretty homogenous group of clinicians [033-3790]
2. You never know how often you're going to have encounters where you need cultural competency [041-4322]
3. In some places I get frequent opportunities to interact with different cultures [044-4322]
4. I've been in others where I have very rare encounters [045-4322]
5. It's hard to predict unless you know that the area you're going to has higher incidence of people with needs that would be cultural [046-4322]

Other Independent Beliefs

1. You approach everyone the same way [021-3796]
2. Spending a lot of time with patients considering healthcare insurance [02-3791]
3. Hard to get to know people in a 45 minute evaluation [029-3791]
4. Over longer periods of time that's tiring [030-3791]
5. I have to constantly adapt to everybody's personality to make them comfortable [031-3791]
6. Clinician's preconceived ideas are a little hard to break through [034-3790]
7. It's knowing where to get the information [035-3961]
8. To know about where different people are coming from [036-3961]
9. I don't know how you teach somebody to be sensitive to that sort of thing [039-4178]
10. You can't teach everybody's culture [040-4178]
11. Defining what cultural competency is [041-4178]
12. I probably have reached my full potential of what I might come in contact with [048-4323]

4. What are your feelings about conducting cultural assessment on all patients?

Theme 1

It would be helpful in diverse service areas (f=3) [001-3800, 018-3794, 039-4322]

Specifics

1. Here I haven't seen as much diversity [002-3800]
2. It would depend on the clinic [003-3800]
3. If that's something that they see a lot of, then it would be very helpful [004-3800]

Theme 2

It would be a good tool (f=3) [007-3799, 016-3794, 027-3961]

Specifics

1. Depends on the questions [017-3794]

Theme 3

Difficult on all patients because of similarity (f=2) [019-3792, 033-3957]

Specifics

1. I don't think it would give us good information because they would be typical Caucasian average, family, average, income [034-3957]
2. Most don't realize they are a different culture such as mine [035-3957]

Theme 4

Not a bad idea (f=2) [008-3798, 021-3791]

Specifics

1. If it's a patient you are not really connecting with, not understanding [009-3798]
2. Then you can ask more intimate questions to make therapy most effective and efficient [010-3798]
3. I haven't had any patient I can think of [022-3791]
4. Few patients would have a problem with that kind of personal questions [023-3791]
5. I don't think it would take much more time [024-3791]
6. Learn about their situation as a whole would help in the initial evaluation to kind of plan care [025-3791]

Theme 5

It would be hard (f=2) [011-3797, 036-4178]

Specifics

1. I don't know how you're going to assess it [037-4178]

Theme 6

Time could be an issue (f=2) [030-3961, 040-4322]

Specifics

1. Get's looked over because you are busy [028-3961]
2. I think it's a judgment call based on the population you're serving [041-4322]

Theme 7

It would be helpful (f=2) [031-3961, 044-4323]

Specifics

1. It would probably get more accomplished [032-3961]

Other Independent Beliefs

1. Visually without asking there's a lot we can do [013-3797]
2. I would use it if it were available [014-3796]
3. I don't know how to go about getting it [015-3796]
4. I wouldn't have a problem asking them questions [026-3790]
5. You want to [029-3961]
6. It would be difficult to come up with a standard way or set of questions that you could ask a group or person [038-4178]
7. At the last clinic, I asked that kind of data [042-4323]
8. It didn't seem like it came up a lot and caused any problem [043-4323]

Secondary question nested in the data set

Is there something in particular that helps you decide that a patient needs cultural assessment?

Theme 1

The way they act/speak (f=5) [003-3799, 005-3798, 007-3797, 012-3792, 017-3961]

Specifics

1. If they don't seem right with the therapy [006-3798]
2. Things we learned to pick up on from class [013-3792]

3. Body language [018-3961]

Theme 2

Something in the medical record (f=2) [001-3800, 014-3971]

Other Independent Beliefs

1. Physical appearance [002-3799]
2. Never had an experience [004-3798]
3. Feel patients are like their personalities [009-3794]
4. I try to listen to them, so see what they tell me, what information they give [010-3794]
5. Ask my questions [011-3794]
6. Work schedule [015-3971]
7. Transportation [016-3971]
8. You can tell if they are very open of if they aren't [019-3957]

5. How do you culturally assess patient?

Theme 1

Communication skill (f=7) [003-3800, 006-3798, 009-3796, 015-3791, 017-3790, 024-4178, 032-4323]

Specifics

1. Ability to speak English [018-3790]

Theme 2

Visual assessment (f=3) [002-3800, 007-3797, 027-4322]

Specifics

1. It's kind of a first impression [001-3800]

Theme 3

Patient Lifestyle (f=2) [011-3794, 019-3790]

Specifics

1. Family life, if they have children [012-3794]
2. Who takes care of them [013-3794]

Other Independent Beliefs

1. See what they are comfortable with [004-3799]
2. Make sure they are aware of what I'm doing before I do it [005-3799]
3. Stereotypes of the different cultures [008-3797]
4. Use the Purnell book [010-3796]
5. I haven't had to do it so far that much [014-3792]
6. Skin color [016-3790]
7. If I didn't understand their issues [022-4178]
8. Emotional issues [023-4178]
9. Patient history [025-4322]
10. Subjective history [026-4322]
11. Sometimes I feel disrespectful initiating conversation without knowing fluency level [028-4322]
12. Introduction on paper [029-4322]
13. You have to use all the tools at your disposal [030-4322]
14. It's a very individual thing [031-4322]

No Response

020-3961

021-3957

6. At what point should a provider culturally assess a patient?

Theme 1

When incongruence is noted (f=9) [005-3799, 008-3797, 011-3794, 013-3972, 015-3790, 017-3957, 021-4178, 022-4322, 023-4323]

Specifics

1. If a patient is uncomfortable [006-3799]
2. They do things we find strange [018-3957]

Theme 2

At initial evaluation (f=6) [001-3800, 002-3799, 077-3798, 009-3796, 012-3972, 014-3791]

Specifics

1. Before there are any problems [003-3799]
2. To prevent issues coming up [004-3799]

Other Independent Beliefs

1. Whenever [010-3794]
2. Every time [016-3961]
3. If they couldn't find a way to relate to their patient [019-4178]
4. If communication was not working [020-4178]

7. When did you first learn about the connection between culture and health?

Theme 1

Cultural Competency class (f=9) [001-3800 003-3799, 009-3796, 015-3792, 016-3791, 017-3790, 019-3691, 026-4178, 010-4323]

Specifics

1. Your class is a different way to look at things [010-3796]
2. The book we read [018-3790]
3. It got me thinking about it more [027-4178]
4. Realizing not everybody sees the world as this medical view that we all accept [028-4178]

Sub-Theme 1

Culture as applied to understanding health (f=2) [002-3800, 004-3799]

Theme 2

Other formal education (f=4) [005-3798, 013-3792, 023-3957, 029-4322]

Specifics

1. When taking out documentation in HIPAA and ethics [014-3792]

Theme 3

Always aware (f=3) [008-3796, 011-3794, 024-3957]

Specifics

1. Taking class probably brought it out more [012-3794]
2. A long time ago [021-3957]
3. With connection between sickle cell anemia and African Americans [022-3957]
4. I knew a little, but was like oh, yeah, all of this is related for every culture until the class [025-3957]

8. Think of a time before you started your formal physical therapy education. Had you gained knowledge of the connection between culture and health before learning about it in your program of study at Wichita State University? If so, can you describe those experiences?

Theme 1

No (f=6) [001-3800, 003-3798, 007-3796, 008-3794, 012-3961, 018-4322]

Theme 2

Through other education (f=4) [005-3798, 009-3792, 013-3957, 016-4178]

Specifics

1. With psychology [014-3957]
2. Just with mental health [015-3957]
3. Worked with a lot of international students [017-4178]

Theme 3

Through family experience (f=2) [006-3797, 010-3791]

Other Independent Beliefs

1. Observations and trial and error [004-3798]
2. I had a little experience [019-4323]
3. I come from a small area, but there is cultural diversity there [020-4323]

No Response

002-3799

9. Think about your current cultural competency education. What do you see as the most important things you learned? How does this help you in your job?

Theme 1

To recognize or understand worldview differences (f=9) [001-3800, 004-3798, 008-3796, 014-3791, 016-3790, 019-3961, 024-4178, 026-4322 029-4323]

Specifics

1. The different ways they view health care [005-3798]
2. That it can be religious preference, sexual orientation, lifestyle, economic level [009-3796]
3. Not everybody has the same value systems or understanding [015-3791]
4. Not assuming everybody has the same religion [017-3791]
5. You have to consider each individual and worldview [025-4178]
6. A lot of us are not aware of that [027-4322]
7. People's values connected to health, because it affects motivation [028-4322]

Theme 2

To listen and learn from patients (f=4) [002-3799, 010-3794, 020-3961, 021-3957]

Sub-Theme 1

To be relativistic (f=3) [003-3799, 011-3794, 018-3961]

Specifics

1. How different cultures act with pain [022-3957]

Other Independent Beliefs

1. I've learned to be very sensitive [006-3798]
2. Just being exposed [007-3797]
3. How to communicate with them [013-3792]
4. It's also about the socio-economic barriers [023-4178]

10. Is there anything in particular that has helped you care for patients?

Theme 1

To be aware of patient differences (f=3) [006-3796, 012-3961, 015-4178]

Specifics

1. They're going to look at things differently [007-3796]
2. I need to be looking out for some differences [016-4178]
3. Being open to differences and opinions [017-4178]
4. Tips about different cultures [018-4178]
5. Gives you better handle on what to do [019-4178]

Theme 2

Communication skills (f=2) [008-3794, 011-3790]

Theme 3

Nothing (f=2) [009-3792, 013-3957]

Other Independent Beliefs

1. The concept that that patient is always right [001-3800]
2. Ask them what they want [003-3798]
3. My bank of knowledge [004-3797]
4. Treating people with respect [005-3796]
5. Family structure [014-3957]
6. How people respond to pain differently [020-4323]
7. You have to be open-minded [021-4323]
8. Have kindness for everyone [022-4323]

No Response

002-3799

010-3791

11. How would you describe cultural competency to others?

Theme 1

Being aware and understanding similarities and differences (f=7) [001-3800, 005-3798, 010-3792, 012-3791, 018-3951, 019-4178, 024-4323]

Specifics

1. You have to be open to learn different cultures [002-3800]
2. Just because it's different doesn't mean it's wrong [020-4178]

Sub-Theme 1

Providers must accommodate patients (f=3) [006-3798, 011-3792, 021-4178]

Theme 2

Being aware of the affect of culture on health (f=2) [003-3799, 022-4322]

Sub-Theme 1

Providers must adapt (f=2) [004-3799, 023-4322]

No Response

007-3979

008-3796

009-3794

013-3790

12. What kinds of things happen in your job that prevent you from being culturally competent?

Theme 1

Time (f=7) [004-3799, 006-3797, 007-3796, 010-3794, 011-3792, 014-3961, 020-4322]

Theme 2

Standards of the clinical narrative (f=4) [015-3961, 016-3957, 017-4178, 021-4322]

Specifics

1. Having to use tools the patients don't understand what they're for [018-4178]
2. Trying to explain the process when they don't understand [019-4178]
3. I don't know if it's a value [022-4322]

Theme 3

Lack of exposure to other cultures (f=3) [003-3800, 005-3798, 012-3791]

Theme 4

Being only a student (f=2) [008-3796, 013-3790]

Other Independent Beliefs

1. Generation gap [001-3800]
2. Not having an open mind [002-3800]
3. Language barrier [023-4323]

13. What are the major challenges in caring for your patients? Do you feel equipped to take on these challenges?

Theme 1

Not being able to relate (f=5) [008-3794, 010-3791, 014-4178, 015-4322, 018-4323]

Theme 2

Lack of confidence (f=4) [004-3798, 005-3797, 013-3957, 016-4322]

Theme 3

Language barriers (f=2) [002-3799, 017-4323]

Other Independent Beliefs

1. Generation gap [001-3800]
2. Different view of medicine and health [003-3799]
3. Distractions that go on while you are trying to treat [006-3797]
4. I don't feel like I have a challenge [011-3790]
5. Their access to help [012-3961]

Nested question

Do you feel you are missing educational skills or information for these challenges?

Theme 1

Lack of exposure to diverse populations (f=3) [001-3800, 005-3957, 006-4178]

Theme 2

No/limited experience in application (f=3) [003-3791, 007-4322, 009-4323]

Specifics

1. Actually having to create a scenario where we are a practitioner in this situation [008-4322]

Other Independent Beliefs

1. I can't think of any [002-3799]
2. We aren't educated enough about government insurance and dealing with people who have government insurance [004-3961]

14. What are some of the ways you learn about worldview differences with patients?

Theme 1

Ask (f=11) [001-3800, 002-3799, 003-3798, 004-3797, 009-3796, 008-3974, 009-3792, 011-3790, 013-3961, 015-4178, 019-4323]

Theme 2

Use the Internet (f=3) [006-3796, 012-3961, 018-4322]

Theme 3

Read (f=2) [005-3796, 017-4322]

Theme 4

Through experience (f=2) [014-3957, 016-4322]

15. How do you feel about talking to patients about differences in explanatory models?

Theme 1

Therapy must be patient-driven (f=4) [011-3796, 022-3792, 034-4178, 040-4322]

Specifics

1. Patients are in pain and don't want to hear that [012-3796]
2. A lot don't understand the surgical procedures [013-3796]
3. They don't want to understand [014-3796]
4. If I think they like a lot of information then I am happy to give it [015-3796]
5. If it doesn't work for them, I'll draw a picture [021-3792]
6. Explain things at the most basic level [035-4178]
7. Let patient know something is normal for their condition seems to ease their mind [036-4178]
8. Going as basic as possible [036-4178]
9. Holistic perspective can come into play [038-4322]
10. With the biomedical model things have become more structured, so formulated, if that's all you stick to you're not able to make adaptations [039-4322]
11. You need to be open [041-4322]
12. There's a degree to where you need to play with the structure a little bit to include people's beliefs [042-4322]

Theme 2

It is a provider's responsibility to the patient (f=3) [001-3800, 004-3799, 016-3794]

Specifics

1. If I understood their model then I could put it in their words and make it easier [002-3800]
2. I need to understand how they see things [003-3800]
3. Patient education is one of the big things to me [017-3794]
4. I like to know personally how they feel [018-3794]
5. A medical diagnosis doesn't mean that they are going to be a carbon copy of the last patient with that [019-3794]
6. Nobody uses the pain scale the same as the last person [020-3794]

Theme 3

I would be open/comfortable (f=3) [007-3798, 026-3790, 033-3957]

Specifics

1. Just talk about it [008-3798]
2. I would be completely open to asking why you think this happened to you [027-3790]
3. I would be completely open to asking what do you think you could do to make it better [028-3790]
4. I don't think there is only one way [029-3790]

Theme 4

I would be hard (f=2) [023-3791, 030-3901]

Specifics

1. I'm such a believer in biomedical [024-3791]
2. I would be okay, but would have a hard time not putting my two cents in [025-3791]
3. As a new clinician you are worried about everything else [031-3961]
4. That would come from experience [032-3961]

Other Independent Beliefs

1. I'm still learning [007-3798]
2. I don't know yet [010-3797]
3. You can only say so much [043-4323]
4. If they aren't going to you can't push them too much [044-4323]
5. It's always worth a try [045-4323]

16. What do you do if you have limited cultural knowledge to provide care to a patient?

Theme 1

Use the Internet/Google (f=6) [001-3800, 010-3794, 016-3792, 018-3791, 019-3790, 023-3957]

Theme 2

Do research (f=5) [002-3799, 008-3794, 014-3792, 017-3791, 020-3790]

Specifics

1. Try my best to find a legitimate source [011-3794]
2. I don't want to make assumptions [012-3794]

Theme 3

Do the best with what I know (f=4) [006-3797, 021-3961, 025-4178, 027-4322]

Specifics

1. It could be more helpful if I was more open minded [022-3961]
2. Go back to the most basic simple terms [026-4178]

Theme 4

Ask other health professionals (f=2) [005-3798, 031-4323]

Theme 5

Ask patient general questions (f=2) [007-3796, 013-3794]

Theme 6

Ask the interpreter (f=2) [024-3957, 030-4322]

Other Independent Beliefs

1. Be respectful [003-3799]
2. That is a weak point in me [009-3794]
3. Do things that are universally acknowledged by human beings, use those things [029-4322]

17. How do you feel about the possibility of having to negotiate with a patient? What are the limits to your negotiation?

Theme 1

Negotiation is a normal part of PT practice (f=6) [002-3799, 015-3794, 018-3792, 027-3657, 029-4179, 037-4323]

Specifics

1. A lot of patients will go to a chiropractor [003-3799]
2. There is nothing wrong with that [004-3799]
3. Say it's your right to get help from other professionals too [005-3799]
4. You don't always get to do what you want with a patient [016-3794]
5. Quality of life is most important, so if they are happy, I'm going to be happy [017-3794]
6. Sometimes there is a struggle [025-3657]
7. You just have to rephrase your words [026-2657]
8. Not everyone is going to appreciate physical therapy like we do [038-4323]
9. A lot of it is learning to cooperate with each other and finding common ground [039-4323]

Theme 2

I'm not comfortable doing so (f=3) [010-3796, 024-3961, 030-4322]

Specifics

1. I know it's part of my job [016-3794]
2. Down the line, I will take that on [012-3796]
3. It is important [013-3796]
4. It is something PTs need to be responsible for [014-3796]
5. Maybe I need to research a little bit more about that [023-3961]
6. I'm more confident with cultures I'm more familiar with [031-4322]
7. I'm still learning [032-4322]
8. I do think that with time that will get better [033-4322]
9. I think it has to be straight experience [034-4322]
10. I don't think it can be case scenarios or classroom setting or papers [035-4322]
11. Emergent experiences always work the best [036-4322]

Theme 3

Don't see a problem (f=2) [007-3798, 021-3790]

Specifics

1. You can only get them to do so much [00-3798]
2. I thing that's a good idea [008-3798]
3. I don't think my way is right [022-3790]

Other Independent Beliefs

1. Find somebody who could care for them better than I, somebody who might understand their culture better [001-3800]
2. If you say your doctor ordered it, your doctor is the almighty [009-3797]
3. That's all well and good as long as insurance is okay with it [020-3791]
4. That would be a little bit stressful [028-4179]

18. Do you feel you have the knowledge or experience to provide culture-based referrals? If not, what limits you?

Theme 1

No (f=11) [001-3800, 010-3797, 013-3794, 014-3792, 015-3791, 016-3790, 018-3961, 019-3957, 021-4179, 024-4323]

Specifics

1. I need more exposure [002-3800]
2. I can maybe recognize [003-3800]
3. I wouldn't feel comfortable until I got exposure in the real world situation [004-3800]
4. I wouldn't feel comfortable doing that right now [012-3796]
5. I think I will, and I definitely will do that [017-3790]
6. Social workers would have answers, so I would go to them [020-3957]

Theme 2

I don't know (f=2) [005-3799, 022-4322]

Specifics

1. I would be willing to look into alternative medicine [006-3799]
2. That would be on my part to look into different things [007-3799]
3. That's something I would seek out [023-4322]

Other Independent Beliefs

1. It's a good idea [008-3798]
2. I'm an advocate for my patients, if I can't get through, then someone else needs to try [009-3798]

19. What do you do if your values or beliefs clash with those of a patient?

Theme 1

Providers must remain open-minded, put their personal beliefs aside (f=8) [009-3796, 012-3794, 014-3792, 017-3791, 018-3790, 021-3961, 026-3957, 033-4323]

Specifics

1. I am a pretty open person [010-3796]
2. I've had a lot of dealing with opposing beliefs [011-3796]
3. I never try to go too in depth with patients [013-3794]
4. You shouldn't influence another patient because of what you believe [015-3792]
5. I have a problem with people who are hateful, but I wouldn't have a problem caring for them [019-3790]
6. Trying to figure out where they are coming from [020-3961]
7. They don't have to agree with what I feel [022-3961]
8. They have the right to believe other things [023-3961]
9. I just ask questions [024-3957]
10. I'm curious about it [025-3957]

Theme 2

Avoidance (f=3) [004-3799, 006-3798 027-4179]

Specifics

1. I don't tell them what I think different [028-4179]

Theme 3

Go along with the patient's beliefs (f=2) [001-380, 005-3799]

Specifics

1. I'm not very confrontational [002-3800]
2. Try to be as respectful as possible [003-3799]

Other Independent Beliefs

1. Hopefully I wouldn't have spoken that [008-3797]
2. It depends on if it affects treatment [029-4322]
3. If it would cause them danger or affect their safety, I would tell them my opinion [030-4322]

4. I can't go through with this procedure if this goes against your belief system [031-4322]
5. It comes down to your respect [032-4322]

20. What additional cultural competency skills do you wish you had?

Theme 1

More general knowledge (f=4) [001-3800, 014-3961, 016-3957, 020-4322]

Specifics

1. More ways to understand where people are coming from [015-3961]

Theme 2

Being bilingual (f=4) [010-3792, 012-3791, 013-3790, 023-4323]

Specifics

1. I want to be able to communicate and relate to them and understand better [011-3792]

Theme 3

More experience (f=3) [004-3798, 006-3797, 021-4322]

Specifics

1. Exposure to a huge variety of different cultures [005-3798]

Theme 4

Knowledge of other alternative practices (f=2) [002-3799, 018-4179]

Specifics

1. Like acupuncture or things like that [003-3799]

Theme 5

Skill in relating to patients (f=2) [019-4179, 024-4323]

Specifics

1. Why they believe certain aspects like the blood transfusion [025-4323]

Other Independent Beliefs

1. I wish what we talked about in class sunk in [007-3796]
2. I wish I felt more comfortable asking more cultural questions when evaluating a patient [008-3796]
3. A standardized tool could be of use [024-4323]

No Response

009-3794

21. Where could you seek additional education or training in cultural competence?

Theme 1

Continuing Education Courses – APTA (f=8) [002-3800, 004-3799, 006-3798, 008-3796, 014-3791, 016-3790, 017-3790, 019-3961]

Specifics

1. Maybe for specific groups rather than just an overview [015-3791]
2. Physical therapy association could offer continued education [020-3961]

Sub-Theme 1

Through WSU (f=2) [005-3799, 021-3957]

Theme 2

Ask an instructor (f=5) [009-3796, 011-3794, 012-3792, 028-4179, 32-4323]

Theme 3

The Internet (f=2) [018-3961, 022-3957]

Sub-Theme 1

APTA website (f=3) [001-3800, 010-379, 013-3791]

Other Independent Beliefs

1. Hands-on experience will be more beneficial [003-3800]
2. The interpreter [024-3957]
3. The social workers [025-3957]
4. Internships [029-4322]
5. Going to an area of location that has a higher population of certain ethnicities or culture groups [030-4322]
6. Going outside of the country [031-4322]

No Response

007-3797

22. If cultural competency education was enhanced, what do you think should be included?

Theme 1

Hands-on/clinical experience (f=7) [001-3800, 005-3798, 008-3796, 014-3791, 017-3790, 019-3961, 024-4323]

Specifics

1. Decrease book work and increase experiences [003-3800]
2. Sitting down and interviewing someone that has a different background [006-3798]
3. Even though it does have a clinical relevance when we learn about it in class, we aren't thinking that way [009-3796]
4. How do I apply that person to person [012-3791]
5. Going somewhere we can see that interaction [013-3791]

Theme 2

Case studies (f=3) [007-3797, 018-3790, 020-3957]

Specifics

1. I'm a hands-on learner [021-3957]

Other Independent Beliefs

1. I like the videos and stuff we watched in class, it's something that did stick with me [002-3800]
2. Complimentary stuff [004-3799]
3. More personal stories [015-3790]
4. I'm not really sure [022-4179]
5. Some previous experience with language of culture class before starting [023-4322]

No Response

010-3794

011-3792

23. What is the greatest cultural barrier in doing your best for patients?

Theme 1

Language (f=6) [001-3800, 008-3792, 010-3791, 013-3957, 016-4179, 019-4323]

Theme 2

Lack of knowledge/understanding (f=5) [002-3799, 004-3798, 007-3794, 009-3791, 014-3957]

Specifics

1. If they are not trusting in what you are doing [003-3799]

Theme 3

I don't know (f=2) [005-3797, 011-3790]

Other Independent Beliefs

1. Being afraid to ask [006-3796]
2. Knowing yourself and what you are comfortable with, what you really believe [012-3961]
3. Communication [017-4322]
4. Communication is more than language, it's culture, it's body language, it's understanding belief systems [018-4322]

APPENDIX G

Major Key-Informant Interview Themes by Intervention Group

Question	8-hour Intervention Group Themes (n=6)	45-hour Intervention Group Themes (n=14)
2. What are your feelings about using cultural competency skills in the clinical environment?	<ul style="list-style-type: none"> • Important (f=5) • Positive (f=2) 	<ul style="list-style-type: none"> • Important (f=11) • Depends on the patient population mix (f=3) • Contributes to better outcomes (f=2)
3. What are the major challenges in doing so?	<ul style="list-style-type: none"> • Knowledge limitations (f=3) • Adequate education (f=2) • Communication issues (f=2) 	<ul style="list-style-type: none"> • Knowledge limitations (f=3) • Not offending patients (f=3) • Communication issues (f=2) • Frequency of interactions with different cultures (f=2)
4. What are your feelings about conducting cultural assessment on all patients?	<ul style="list-style-type: none"> • A good thing (f=3) • When there is a cultural misunderstanding (f=2) • Unnecessary when treating a patient similar to the provider (f=2) • Difficult because of time limitations (f=2) 	<ul style="list-style-type: none"> • Helpful in diverse service areas (f=3) • A good tool (f=3) • Difficult on all patients due to similarity (f=2) • Not a bad idea (f=2) • It would be hard (f=2) • Time could be an issue (f=2) • It would be helpful (f=2)
5. How do you culturally assess patients?	<ul style="list-style-type: none"> • Observation (f=3) • Communication skills (f=3) • Patient and provider interactions (f=3) 	<ul style="list-style-type: none"> • Communication skills (f=7) • Visual assessment (f=3) • Patient lifestyle (f=2)
6. At what point should a	<ul style="list-style-type: none"> • Initial evaluation (f=3) 	<ul style="list-style-type: none"> • When incongruence

provider culturally assess a patient?	<ul style="list-style-type: none"> • Not necessary at each evaluation (f=2) • Before you meet the patient (f=2) 	<ul style="list-style-type: none"> • is noted (f=9) • Initial evaluation (f=6)
7. When did you first learn about the connection between culture and health?	<ul style="list-style-type: none"> • CC class (f=2) • Undergraduate education (f=2) • Cross-cultural exposure (f=2) 	<ul style="list-style-type: none"> • CC class (f=9) • Other formal education (f=3) • Always aware (f=3)
8. Think of a time before you started your formal physical therapy education. Had you gained knowledge of the connection between culture and health before learning about it in your program of study at WSU?	<ul style="list-style-type: none"> • Yes (f=6) 	<ul style="list-style-type: none"> • No (f=6) • Through other education (f=4) • Through family experience (f=2)
9. Think about your current cultural competency education. What do you see as the most important things you learned?	<ul style="list-style-type: none"> • Awareness (f=6) • Application to health care and physical therapy (f=2) 	<ul style="list-style-type: none"> • To recognize or understand worldview differences (f=9) • To listen and learn from patients (f=3)
10. Is there anything in particular that has helped you care for patients?	<ul style="list-style-type: none"> • Awareness (f=4) 	<ul style="list-style-type: none"> • Awareness (f=3) • Communication skills (f=2) • Nothing (f=2)
11. How would you describe cultural competency to others?	<ul style="list-style-type: none"> • Cultural awareness (f=3) • Ethnic and lifestyle knowledge (f=2) 	<ul style="list-style-type: none"> • Cultural awareness (f=7) • Awareness of affect of culture on health (f=2)
12. What kinds of things happen in your job that prevent you from being culturally competent?	<ul style="list-style-type: none"> • Time constraints (f=3) • Lack of exposure to diverse populations (f=2) 	<ul style="list-style-type: none"> • Time constraints (f=7) • Standards of clinical process (f=4) • Lack of exposure to diverse cultures (f=3) • Being a student (f=2)
13. What are the major challenges in caring for your patients? Do you feel equipped	<ul style="list-style-type: none"> • Language (f=3) 	<ul style="list-style-type: none"> • Not being able to relate (f=5) • Lack of confidence

to take on these challenges? Do you feel you are missing educational skills or information for these challenges?		(f=4) • Language (f=2)
14. What are some of the ways you learn about worldview differences with patients?	<ul style="list-style-type: none"> • Ask (f=4) • Learn from others (f=2) 	<ul style="list-style-type: none"> • Ask (f=11) • Use the Internet (f=3) • Read (f=2) • Through experience (f=2)
15. How do you feel about talking to patients about differences in explanatory models?	<ul style="list-style-type: none"> • Haven't experienced it yet (f=3) • Good (f=2) • I will provide my point of view (f=2) 	<ul style="list-style-type: none"> • Therapy must be patient-driven (f=4) • A provider responsibility to the patient (f=3) • I would be open or comfortable (f=3) • It would be hard (f=2)
16. What do you do if you have limited cultural knowledge to provide care to a patient?	<ul style="list-style-type: none"> • Ask questions (f=4) • Talk to other health professionals (f=3) • Use the Internet (f=2) 	<ul style="list-style-type: none"> • Use the Internet (Google) (f=6) • Do research (f=5) • Do the best with what I know (f=4) • Talk to other health professionals (f=2) • Ask the patient (f=2) • Ask the interpreter (f=2)
17. How do you feel about the possibility of having to negotiate care with a patient? What are the limits to your negotiation?	<ul style="list-style-type: none"> • Okay with negotiation (f=5) 	<ul style="list-style-type: none"> • Negotiation is part of PT practice (f=6) • Not comfortable negotiating (f=3) • No problem (f=2)
18. Do you feel you have the knowledge or experience to provide culture-based referrals? If not, what limits you?	<ul style="list-style-type: none"> • No (f=2) • Yes (f=2) 	<ul style="list-style-type: none"> • No (f=11) • I don't know (f=2)
19. What do you do if your values or beliefs clash with those of a patient?	<ul style="list-style-type: none"> • Patients don't need to believe as providers (f=6) • Quality of care is most important (f=2) 	<ul style="list-style-type: none"> • Providers must be open minded (f=8) • Avoidance (f=3) • Go along with the patient's beliefs

		(f=2)
20. What additional CC skills do you wish you had?	<ul style="list-style-type: none"> • More knowledge (f=3) • Better translation-use skills (f=2) • Knowing how to ask culture questions (f=2) 	<ul style="list-style-type: none"> • More knowledge (f=4) • Being bilingual (f=4) • More experience (f=3) • Knowledge of alternative practices (f=2) • Skill in relating to patients (f=2)
21. Where could you seek additional education or training in CC?	<ul style="list-style-type: none"> • Continuing education (f=4) • The Internet (f=2) • Written materials (f=2) 	<ul style="list-style-type: none"> • Continuing education (APTA) (f=8) • Ask an instructor (f=5) • The Internet (f=2)
22. If CC education were enhanced, what do you think should be included?	<ul style="list-style-type: none"> • No themes emerged 	<ul style="list-style-type: none"> • Hands-on experience (f=7) • Case studies (f=3)
23. What is the greatest cultural barrier in doing your best for patients?	<ul style="list-style-type: none"> • Language issues (f=3) 	<ul style="list-style-type: none"> • Language issues (f=6) • Lack of knowledge (f=5) • I don't know (f=2)

APPENDIX H

Competencies Addressed: Revised 10-Week Educational Format

Module Content and Activities	Objectives
Clinical Professionalism and the Concept of “Cultural Competence”	<ul style="list-style-type: none"> • Explain why “cultural competence” gained attention in health services • Describe the relationship between cultural competence and disparate health outcomes • Review discipline-based standards for cultural competency • Discuss legal and policy positions requiring demonstrations of cultural-competency education for fulfillment of accreditation standards in health services • Discuss limitations to outcomes research in cultural-competency education • Discuss limitations to a cultural-competency approach in clinical practice
The Meaning of Sickness and Healing Universal Biology vs. Local Reality	<ul style="list-style-type: none"> • Discuss approaches to the concept of culture • Complete class exercises demonstrating worldview and the ordering of reality • Discuss limitations to “knowing” another’s culture • Discuss assumptions that disease is universal • Discuss interpretation of symptoms into disease • Discuss classification and compartmentalization of the body • Discuss how health is normalized • Discuss how illness is diagnosed • Discuss sickness narrative and the construction of meaning • Discuss social role of being sick • Discuss self-care vs. health seeking • Discuss the meaning of healing as both science and art
Biomedicine & Medical Reality	<ul style="list-style-type: none"> • Discuss history, structure, and significance of biomedicine as more than discovery of facts • Describe biomedicine’s success as shaped by social and political factors • Discuss ideas, values, and dichotomies embedded in the biomedical system • Compare biomedicine to ethnomedicine • Debate dangers in interpreting biomedicine as

	<p>science and ethnomedicine as beliefs</p> <ul style="list-style-type: none"> • Discuss role of biological authority, knowledge, and uncertainty in healing • Describe how medical education transforms into power and position • Discuss how educational “silos” construct medical and clinical realities • Analyze medicine as a system of social control with its own rules and boundaries • Analyze role of “legitimacy” in healing • Debate abuse of power in healing • Discuss increasing legitimacy and ownership of all that is “medicalized”
Life Course & Technologies	<ul style="list-style-type: none"> • Define concept of life course • Discuss biases and definitions of life course stages in Western world • Discuss rites of passage and liminality associated with life course stages • Compare differences in life course construction • Analyze limitations to the construct of “aging” • Evaluate medical and legal limitations of birth and death • Discuss intersection of life course and technologies • Describe how technologies drive change in health services • Describe commodification and branding of technologies • Examine differences in acceptance of technologies
Personhood & Identity	<ul style="list-style-type: none"> • Describe notion of personhood • Compare differences in personhood construction • Describe illness as challenge to personhood • Compare cultural variation in identity and gender construction • Debate effect of identity and gender on social worth of patients • Define difference between race and ethnicity • Define scientific limitations to concept of race in understanding health and disparity • Debate effects of race and ethnicity in eliciting differing responses from health providers • Discuss “roses” and “thorns” of providing health in a pluralistic society

	<ul style="list-style-type: none"> • Describe limitation to current research on race and ethnicity and health outcomes
Stress, Pain & Religion	<ul style="list-style-type: none"> • Describe general adaptation syndrome (GAS) stress model • Compare differences in perception of stress and pain • Describe role of religion and prayer for stress and pain • Discuss private pain vs. public pain • Describe cognitive and emotional functions of religion • Discuss narrative and chronicity
Mental Health, Stigma & Suffering	<ul style="list-style-type: none"> • Discuss conditions with authority and conditions open to challenge • Define and discuss idioms of distress • Describe culture-bound syndromes • Discuss differences between “having” and “being” • Discuss culture of disability • Discuss biomedical rationality and irrationality • Describe moral interpretations of sickness and suffering
Health Literacy & Communication	<ul style="list-style-type: none"> • Discuss the language of clinical medicine • Discuss connection between general literacy, health literacy and cultural competency • Discuss culturally and linguistically appropriate services (CLAS) standards and Joint Commission accreditation • Describe negative health outcomes associated with low health literacy • Discuss standards and limitation when using translators and interpreters • Describe importance of congruent explanatory models
Humility & The Person-Centered Approach	<ul style="list-style-type: none"> • Evaluate how health services provider’s values affect and shape clinical encounters • Discuss provider’s responsibility toward positions of humility as necessary professionalism • Debate provider’s responsibility to uphold standards that do not abuse power and hierarchy in clinical encounters • Introduce use of ethnographic methods in clinical care

	<ul style="list-style-type: none"> • Discuss responsibility of clinical interpretation and the “beliefs of others”
Changing the Model Through Culture-Brokering	<ul style="list-style-type: none"> • Define culture-brokering and its application in clinical care • Discuss how to create culturally informed programs of care • Discuss legal limitations of and process for coordinating with traditional healers • Discuss methods for negotiating care for mutual outcomes • Discuss ethical dilemmas that can arise from negotiation of care • Describe ways to responsibly advance culturally informed care

APPENDIX I

Sample Case Study on Culturally Informed Care

Patient Information: Joaquin Miller, 27 year old non-Hispanic, Caucasian male

Setting: sports medicine specialty out-patient clinic

Diagnosis: type I SLAP tear

Therapy Plan: rotator cuff strengthening, neuromuscular re-education of scapular stabilization musculature

Case Narrative

Mr. Miller is a semi-professional baseball player who gained national attention during his college career for athletic performance and academic achievement. He played in the minors for two years and there was increasing buzz that he would be called to the big show this year.

Mr. Miller has three children and is married to his high-school sweetheart. He supports his family which includes his mother, father, and two younger brothers. Mr. Miller is proud to be able to care for his family and they are continually gracious for his support.

Mr. Miller's injury came as a direct result of showing off at training camp before the regular season began. He has been placed on the injured list, his minor contact is in jeopardy, and the major league has cooled talk of his advancement. At the first two therapy sessions Mr. Miller broke down in tears in the therapy gym and acted out in frustration at the physical therapist providing his care. Mr. Miller has come to his third visit with no progress; in fact it appears he may have aggravated the injury. Mr. Miller is complaining that the "exercises" he is supposed to do are too easy and he doesn't believe they will help him return to play during the season. All of his conversations focus on his desperation to play baseball again as soon as possible, but he refuses to follow the physical therapist's recommendations and has remained verbally abusive.

Discussion Questions

1. What questions could the physical therapists ask to assess Mr. Miller's worldview?
2. What can the physical therapists do to feel more comfortable providing Mr. Miller's care?
3. How might the physical therapists enlist the help of this client's family to facilitate therapy?
4. What problems might evolve when working with family members to enhance therapy?
5. Are there other service referrals or collaborations that could improve Mr. Miller's care?
6. What can the physical therapists do to create a *culturally-informed* care plan for Mr. Miller?
7. How can the physical therapists help Mr. Miller reframe the therapy process?